

Resident Physician

March 1984, Volume 2, Number 3

Physician Placement Agencies

Your Practice Needs Printing

The Foreign Resident: His Initial Problems

Resident Roundtable

Guest Editorial

New England Medical Center

Clinico-Pathological Conference

The Doctor Speaks Yiddish

Internal Medicine Board Requirements

Equipping the Surgeon's Office

Mediquiz

What's the Doctor's Name?

Journal for the Hospital Resident



sugar and spice and . . . gastric hyperacidity

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References: 1. Pocock, D. G.:
Personal communication.
2. Harding, C. W.: Personal
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W. M.: Personal communi-
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Supplied: Tablets, 5 mg.
(yellow) and 10 mg. (blue);
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*Sacks, M. S.: Ann. Int. Med. 42:458 (Feb.) 1955.



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Resident Physician

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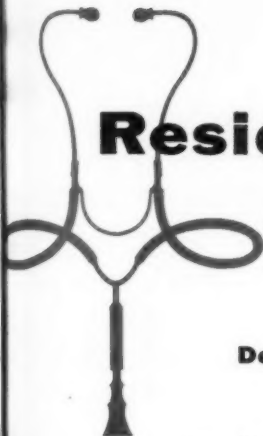
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*Verse by
RICHARD ARMOUR
Illustrations by
LEO HERSHFIELD

IGNORANCE ISN'T BLISS *

There is an awful, quite unlawful,
Violent and dread ache
That should have fame and Latin name
And yet is called "a headache."

The victim thinks his head's in kinks,
Or, from the inner clamor,
Some hidden sprite with all his might
Is banging with a hammer.

He seems to feel that rods of steel
Are thrusting through his cranium.
In state so vile, he couldn't smile
To hear he'd struck uranium.

Poor soul is he who hopelessly
Is sick as hell with migraine
(And pity, too, this person who
Must not have heard of Wigraine.)

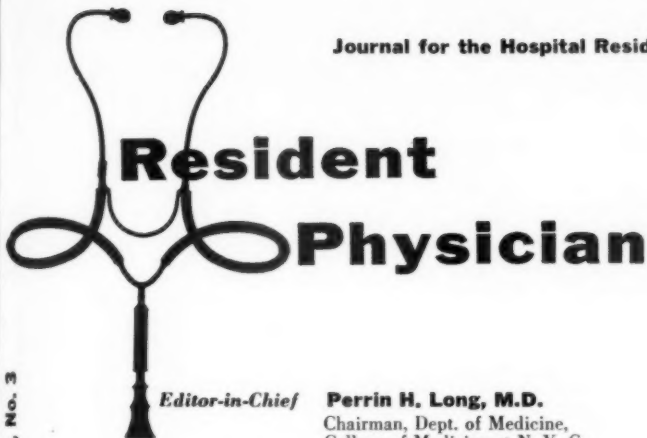


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1Watts, J. C., and Ruthberg, J.: *Ann. Int. Med.* 29: 1104 (Dec.) 1948.

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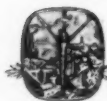
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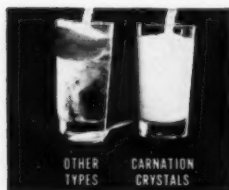
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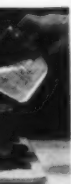
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a "judicious combination..."

for antiarthritic therapy

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That cortisone and the salicylates have a complementary action has been well established.^{1,2} In rheumatic conditions, functional improvement and a sense of feeling well are noted early. No withdrawal reactions have been reported.

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INDICATIONS:

Rheumatoid arthritis . . . Rheumatoid spondylitis . . . Rheumatic fever . . . Bursitis . . . Still's disease . . . Neuromuscular affections

EACH TABLET CONTAINS:

Cortisone acetate	2.5 mg.
Sodium salicylate	0.3 Gm.
Aluminum hydroxide gel, dried	0.12 Gm.
Calcium ascorbate	60 mg.
(equivalent to 50 mg. ascorbic acid)	
Calcium carbonate	60 mg.

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1. Busse, E.A.: Treatment of Rheumatoid Arthritis by a Combination of Cortisone and Salicylates. *Clinical Med.* 11:1105 (Nov., 1955).

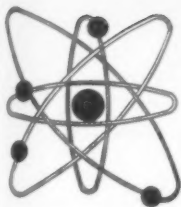
2. Roskam, J., VanCawenberge, H.: *Abst. in J.A.M.A.*, 151:248 (1953).

3. Coventry, M.D.: *Proc. Staff Meet., Mayo Clinic*, 29:50 (1954).

4. Holt, K.S., et al.: *Lancet*, 2:1144 (1954).

5. Spies, T.D., et al.: *J.A.M.A.*, 159:645 (Oct. 15, 1955).

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Viewbox Diagnosis

Edited by Maxwell H. Poppel, M.D., F.A.C.R.,
Professor of Radiology, New York University College of Medicine
and Director of Radiology, Bellevue Hospital Center

WHICH IS YOUR DIAGNOSIS

- | | |
|------------------------|--------------|
| 1. Food in the stomach | 3. Carcinoma |
| 2. Bezoar ulcer | 4. Gastritis |

(Answer on page 146)



PARENZYME® INTRAMUSCULAR TRYPSIN, in HOSPITAL USE

From the literature

"It is difficult to fail to be impressed with a drug which like penicillin, or cortisone, has an almost accurately predictable and unfailing effect, and which is capable of reversing pathological changes of long standing."¹

"A salutary effect on the thrombophlebitic process was elicited. The per patient hospital stay averaged 19 plus days for those not receiving trypsin, against 9 plus for those who did receive it."²

Direct anti-edema, anti-inflammatory action has many applications in the wards, emergency rooms and out-patient clinics. Advantages of PARENZYME, *Intramuscular Trypsin*:

- Safe method of administering parenteral trypsin; no major side effects; not anticoagulant
- can be used in conjunction with any other therapy prescribed
- early ambulation and return to full activity
- tends to enhance use of antibiotic therapy

Time between photos 9 weeks



LEFT: Female diabetic, 72 years old. Peripheral arteritis obliterans, with cellulitis and gangrenous ulcerations. Burning pain.

RIGHT: PARENZYME administered daily. Healing of ulcer complete. Pain and edema eliminated.

INDICATIONS: The cardinal indication for PARENZYME is acute inflammation regardless of etiology. **TRAUMATIC WOUNDS:** slow-healing wounds, bruises, contusions, black eyes. **SKIN ULCERS:** decubitus, varicose, diabetic. **VASCULAR DISORDERS:** phlebitis, thrombophlebitis, phlebothrombosis. **OPHTHALMIC:** iritis, iridocyclitis, chorioretinitis.

DOSAGE: 2.5 mg. (0.5 ml.) intragluteally q. 6 h. until improvement results; q. 12 h. thereafter. **RECOMMENDED METHOD OF INJECTION:** Very slowly intragluteally. **SUPPLIED:** 5 ml. multiple-dose vials (5 mg. trypsin/ml.).

REFERENCES: 1. Wildman, P. J. *Intramuscular Trypsin in the Treatment of Chronic Thrombophlebitis*. Angiology, Oct. 1955. 2. Selligman, B. *Clinical Experience with Trypsin*. Ohio State Medical Journal, 51, May 1955.

The film, CLINICAL ENZYMOLOGY, is available for showing at all hospital meetings upon request.

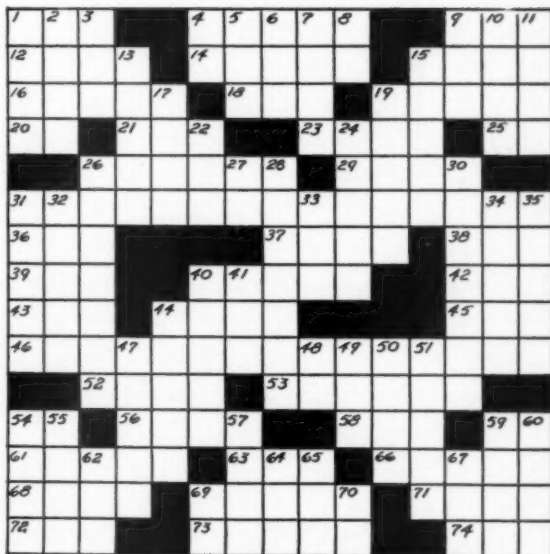


Resident Relaxer

(Answer on page 146)

ACROSS

1. Professional organization
4. Rectal injection
9. Fragment of red cell in malaria
12. Pathology (colloq.)
14. Propelled, as a boat
15. Protuberance
16. Bathe in liquid
18. Sebaceous cyst
19. Repasts
20. Electrical engineer
21. To be sick
23. Narcotic addict (slang)
25. Latin conjunction
26. Element having even-numbered valency
29. Root of Piper methysticum
31. A sexual reproduction
36. Floor covering
37. Voucher (slang)
38. Policeman (slang)
39. Natural source of chemical
40. South American
42. —ocy, extreme mental deficiency
43. Metallic element
44. Middle (prefix)
45. To bind
46. Depressing to sexual appetite
52. In the matter of (two words)
53. Stationary
54. Duration tetany (abbr.)
56. Primitive plant
58. Desire
59. Cerium (sym.)
61. Carries away by force
63. Type of grain
64. Wall painting
68. Love
69. Pertaining to the bones (prefix)
71. The body, exclusive of limbs



72. Convened
73. Mourns, as at a wake
74. Metric unit

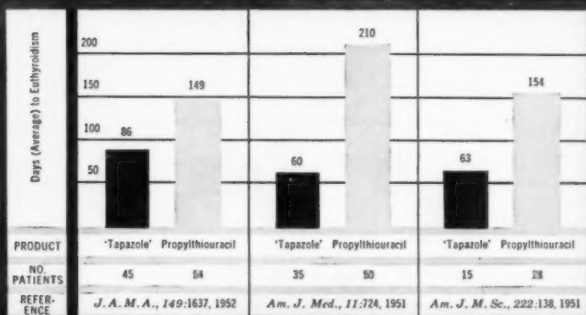
DOWN

1. Part of a church
2. Match
3. Consumed
4. Erbium (sym.)
5. At this instant
6. Female sheep
7. Bill of fare
8. Right ear (abbreviation)
9. Kind of snake
10. Unemployed
11. Defeat

13. Vital organ
15. Impulse carrier
17. Bone marrow
19. Intended
22. To be situated
24. Figure in early karyokinesis
26. Genitive of silver (Latin)
27. Article
28. Physicians
30. Pertaining to peritoneal fluid
31. First (prefix)
32. Rosolic acid
33. Butter used as base for ointments in India
34. Proprietary remedy containing stillingia, menispermum, etc.

35. Talk rapidly
40. Victim of Hansen's disease
41. In combustible residue
44. Female horses
47. Deduce
48. Old tuberculin
49. Twenty-four hours
50. Object
51. Cavity
54. Measure of weight
55. Domesticated
57. Facial feature
59. Arrived
60. Spirit
62. Cooking vessel
64. Devoured
65. Number

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'Tapazole'

(METHIMAZOLE, LILLY)

*"... by far the most rapidly acting antithyroid compound with which we have had experience."**

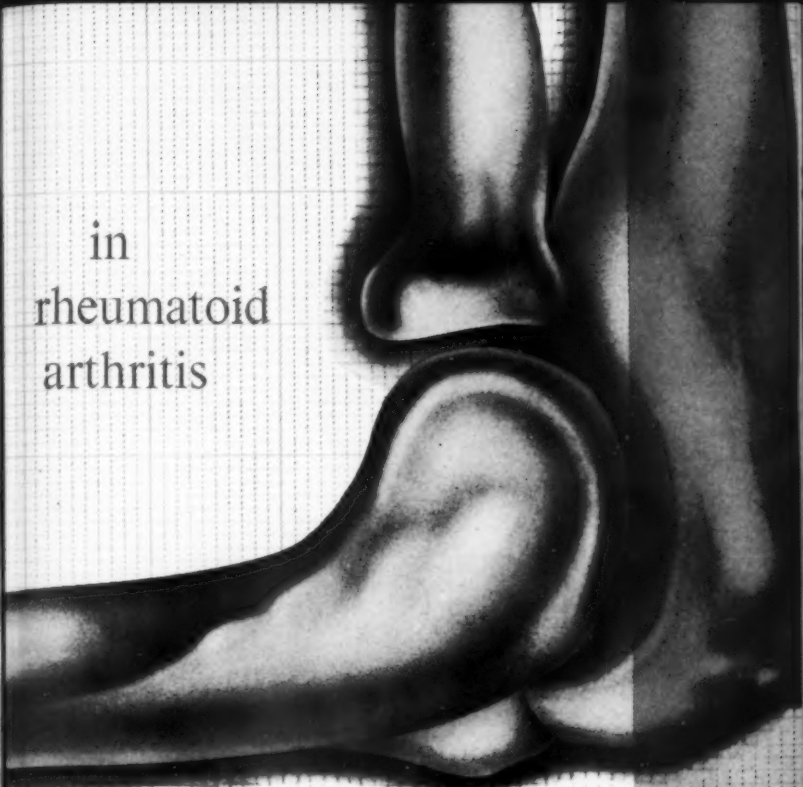
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*J. Clin. Endocrinol., 14:948, 1954.

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*replaces cortisone and hydrocortisone
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- excellent relief of pain, swelling, tenderness
- effective in smaller dosage

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the first orally effective flissive†

dosage: Adults—1 to 2 tablets three to four times a day
with food or immediately after meals. Children—1 tablet two to four
times a day.

supplied: Yellow, scored tablets in bottles of 50.

flissive: Spasmolysis without interference
with normal function.

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of skeletal muscle
in musculoskeletal and
neurological disorders
effective up to 6 hours**

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not a mephenesin derivative

FLEXIN provides superior and long lasting—up to 6 hours—spasmolysis of voluntary muscle in low back syndromes, fibrositis, strains, sprains, and in noninflammatory rheumatic and arthritic disorders.

Striking results are reported in cerebral palsy. Over 65 per cent of spastics obtained definite reduction of excessive muscle tone. In addition, a highly significant number of patients with multiple sclerosis, spinal spasticity and Parkinsonism were benefited.

Letters to the Editor



*Unsigned letters will neither
be published nor read.
However, at your request,
your name will be withheld.*

Sabotage!

I would be inclined to mark this nasty bit of sabotage of the South down as a damnyankee trick except for the fact that you've got a number of editors on your advisory board who I know to be Southern born and bred. Please note that in anybody's projection of population, Virginia's rate of growth is among the top ten states. This doesn't even include carpetbaggers.

We like the journal but don't push us too far.

R. W. L.

Norfolk, Virginia

Man, what y'all tryin t'do—start it up again? . . .

H. Randolph Lee, M.D.

Miami, Florida

. . . Don't tread on me! . . .

M. S. Warner

Alexandria, Va.

I think it only fair to give the beauti-

ful state of Virginia her proper due. As a Bostonian, I was taught in school that Massachusetts had everything—EXCEPT that Virginia was settled in 1607 (although you have unsettled her by your omission) whereas Massachusetts (an associate of Virginia in the original 13 states), can claim 1620 as her earliest settlement.

Roger W. Miller, M.D.

Boston, Mass.

What will I do with the star I've taken off the flag? It's funny, I was almost certain there were 48 all this time.

George Kingsley, M.D.

Los Angeles, Calif.

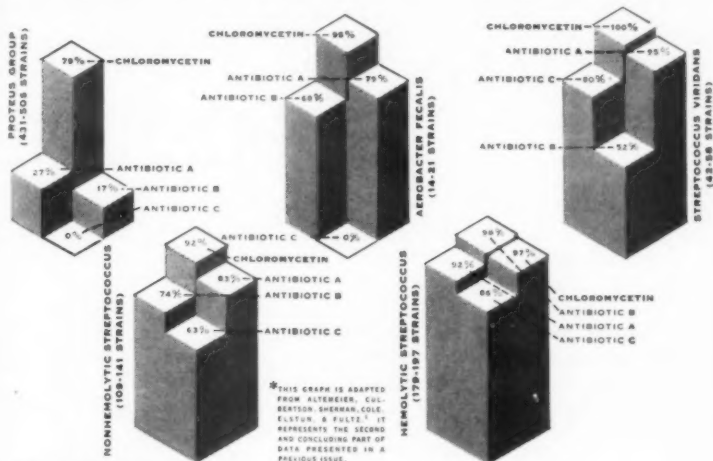
Apologia Virginia

Virginia's recent Resolution of Interposition doesn't mean the Old Dominion has seceded from the Union, Suh . . . yet. While reaffirming the rights of sovereign states we should doubtless have included the right of

—Continued on page 39

Resident Physician

Sensitivity of Common Pathogens to CHLOROMYCETIN and Three Other Major Antibiotic Agents*



REFERENCES: (1) Altmeier, W. A.; Culbertson, W. R.; Sherman, R.; Cole, W.; Elston, W., & Fultz, C. T.: *J.A.M.A.* 157:303, 1955. (2) Weil, A. J., & Stempel, B.: *Antibiotic Med.* 1:319, 1955. (3) Jones, C. P.; Carter, B.; Thomas, W. L., & Creadick, R. N.: *Obst. & Gynec.* 5:365, 1955. (4) Austrian, R.: *New York J. Med.* 55:2475, 1955. (5) Murphy, F. D., & Waisbren, B. A., in Murphy, F. D.: *Medical Emergencies: Diagnosis and Treatment*, ed. 5, Philadelphia, F. A. Davis Company, 1955, p. 557. (6) Felshin, G.: *J. Am. M. Women's A.* 10:51, 1955. (7) Kass, E. H.: *Am. J. Med.* 18:764, 1955. (8) Tebrock, H. E., & Young, W. N.: *New York J. Med.* 55:1159, 1955. (9) Stein, M. H., & Gerschman, E.: *New England J. Med.* 252:906, 1955. (10) Branch, A.; Starkey, D. H.; Rodgers, K. C., & Power, E. E., in Welch, H., & Marti-Ibáñez, F.: *Antibiotics Annual*, 1954-1955, New York, Medical Encyclopedia, Inc., 1955, p. 1125. (11) Munroe, D. S., & Cockcroft, W. H.: *Canad. M. A. J.* 72:586, 1955. (12) Norris, J. C.: *M. Times* 83:253, 1955.

effective against more strains

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Resistant microorganisms frequently cause poor, delayed, or no response to antibiotic therapy. Because *in vitro* sensitivity tests are valuable guides in determining the antibiotic most likely to produce optimal clinical response, it is important that such tests be employed whenever possible. Recent clinical and laboratory studies¹⁻¹² show that **CHLOROMYCETIN** (chloramphenicol, Parke-Davis) is effective against more strains of microorganisms than other commonly used antibiotics.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

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TO PREVENT
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THE HIGH INCIDENCE OF recurring cases after successful treatment is outstanding in vaginal trichomoniasis. Donald observed in 219 cases "... there was a history of previous attacks in 73 (33%)."¹

Trichomonads in husbands—Draper says: "The presence of trichomonads in the male genito-urinary tract should always be suspected in the husband of a woman who is repeatedly reinfected."² Karnaky found the parasite in the urethra and prostate or under the prepuce of 38 among 150 husbands with infected wives.³

Carrier cases—Usually the husband re-infects the wife unknowingly. Males harboring trichomonads may be free from symptoms.³⁻⁸

Protection for wives—To prevent re-infection Draper,² Bernstine and Rakoff,⁴ Davis,⁹ and Karnaky¹⁰ advise use of the condom during coitus.

When treating the wife, explain the role of the husband in trichomoniasis and his part in eliminating her infection. To make explanation easier, we have prepared a booklet for your patients, "How THE HUSBAND CAN HELP." Copies on request.

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cribe RAMSES[®] rubber prophylactics—transparent, very thin, yet strong.

Your prescription of Schmid condoms assures products of finest quality, avoids embarrassment and wins appreciation for your thoughtfulness. Prescribe Schmid protection for as long as four to nine months after the wife's infection has cleared.

Treatment for vaginal trichomoniasis—Select a trichomonacide you know will eliminate trichomonads. Data show better than 90 per cent cures with VAGISEC[®] liquid using the Davis technique.[†] VAGISEC liquid explodes trichomonads within 15 seconds after contact.¹¹

References: 1. Donald, I.: Brit. M. J. 2:1223 (Dec. 6) 1952. 2. Draper, J. W.: Internat. Rec. Med. 168:563 (Sept.) 1955. 3. Karnaky, K. J.: Urol. & Cutan. Rev. 48:812 (Nov.) 1938. 4. Bernstine, J. B., and Rakoff, A. E.: Vaginal Infections, Infestations and Discharges, New York, The Blakiston Co., 1953. 5. Lanceley, F., and McEntegart, M. G.: Lancet 1:668 (Apr. 14) 1953. 6. Freed, C. F.: South African M. J. 22:223 (Mar. 27) 1948. 7. Lanceley, F.: Brit. J. Ven. Dis. 29:213 (Dec.) 1953. 8. Sorel, C.: Mod. Med. 21:166 (Apr. 1) 1953. 9. Davis, C. H.: West. J. Surg. 63:53 (Feb.) 1955. 10. Karnaky, K. J.: J.A.M.A. 155:876 (June 26) 1954. 11. Davis, C. H.: J.A.M.A. 157:126 (Jan. 8) 1955.

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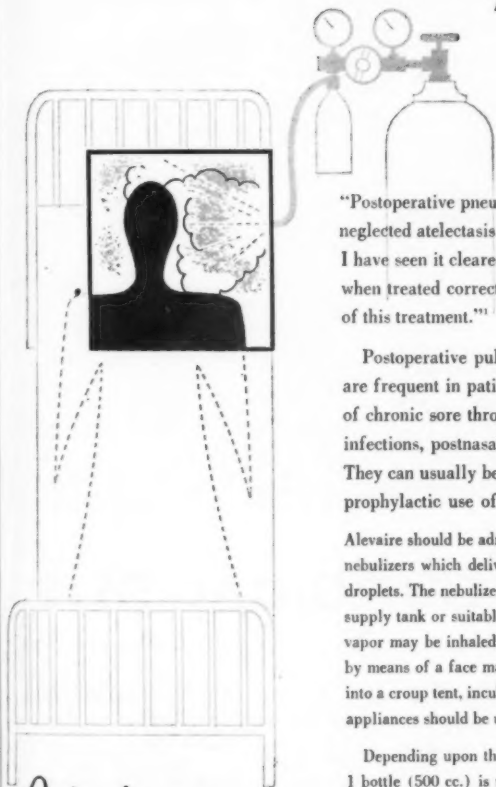
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"Postoperative pneumonia is almost always neglected atelectasis and must be treated as such. I have seen it cleared up within a few hours when treated correctly. Alevaire is part of this treatment."¹

Postoperative pulmonary complications are frequent in patients with a history of chronic sore throat, chronic cough, sinus infections, postnasal drip or heavy smoking. They can usually be prevented by the prophylactic use of Alevaire.

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Depending upon the output of the nebulizing device 1 bottle (500 cc.) is usually sufficient to last from eight to twenty-four hours.

Supplied in bottles of 60 cc. and 500 cc.

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¹ Sadove, M.S.: Paper read at Meeting of the Champaign County Medical Society, Champaign, Ill., Mar. 12, 1953.
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For more than twenty-five years, PYRIDIUM has been employed to provide rapid pain relief for the patient suffering from pyelonephritis, cystitis, urethritis or prostatitis. In a matter of minutes, long before antibiotics, sulfonamides or other antibacterial measures can take effect, this nontoxic and widely-used urinary analgesic overcomes dysuria, frequency, urgency, nocturia or tenesmus. At the same time, PYRIDIUM imparts an orange-red color to the urine which gives the patient psychological assurance that PYRIDIUM is at work. Used alone or in combination, versatile PYRIDIUM may be readily adjusted to the need of a specific patient.

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widely prescribed because of these important advantages:

- 1) rapid diffusion and penetration
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TETRACYCLINE with STRESS FORMULA VITAMINS

Attacks the infection, bolsters the body's natural defense. Stress vitamin formula suggested by the National Research Council in *dry-filled, sealed capsules* with ACHROMYCIN, 250 mg.

Also available: ACHROMYCIN SF ORAL SUSPENSION (Cherry Flavor), 125 mg. per 5 cc. plus vitamins.



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Lederle

Continued from page 22

being represented in the roster of states on page 36 of your January issue under the heading, "Where will you be?" Ask that question of yourself, Mr. Editor, and the answer is "Not in Virginia, Suh." You wouldn't dare!

As for residents looking for fertile fields in which to locate their first practice, the following statistics will be interesting. Virginia on July 1, 1955 had an estimated population of 3,579,000. The figure for 1965 is expected to be 4,271,000. The percentage increase is 19.3%, which is greater than that predicted for any of 40 other states!

G. Mallory Freeman
Advertising Manager
A. H. Robins Company, Inc.
Richmond 20, Virginia

If any of your proofreaders are from the Deep South I would suggest the following punishment: No cornbread, turnip greens or grits 'n' gravy for 30 days. . . . I know this is harsh, but stern measures are called for. . . .

L. T. Wainright, M.D.
Atlanta, Ga.

Sharp-eyed readers used their opportunity to sharpen their pens on this booboo. Letters from many states, some without southern postmarks, put us right. Our thanks to all who troubled to write—and our apologies, heartfelt.

Language reprints

I enjoyed very much receiving RESIDENT PHYSICIAN and would like to extend my best wishes for your success. I am a staff man at this hospital where a large number of Spanish-speaking employees are treated. Your article "The Doctor Speaks Spanish," is exactly what I have been looking for, for myself, my residents, and interns, to facilitate improved history-taking and care of patients in this group. I would appreciate ten copies of this article. I shall be pleased to cover any charge made.

Norman H. Steiner, M.D.
Southern Pacific Company
Hospital Department
San Francisco 17, Calif.

. . . If at all possible, I would appreciate copies of the back numbers containing the "brief guides to foreign phrases." When these are finally put in booklet form you may consider this letter as an order for seven copies.

William H. Foley, M.D.
Director of Medical Education
Roger Williams General Hospital
Providence 8, Rhode Island

We are holding all orders for the language article reprints until the final article of this series appears next month. At that time, all articles will be reprinted in a single booklet and copies will be available at cost to all who desire them.

“... power over
the motion of
the heart...”

—William Withering

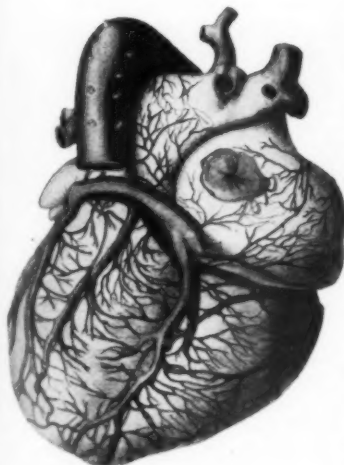


Illustration of a heart
from Cloquet's "Anatomie
de l'Homme," Paris 1850

Empirically, cardioactive drugs have served mankind for more than three millennia: the Ebers Papyrus (ca. 1500 B.C.) records the Egyptians' medical use of squill, and through the centuries substances prepared from various plants and from the venom or dried skin of toads have been used for their cardiotonic action. Digitalis itself was known as early as 1250; and in 1785 William Withering wrote down many still-valid principles in the use of this plant. He used it primarily for relieving dropsy, but did not associate this with the cardiac action of the drug, though he recognized that "It has a power over the motion of the heart to a degree yet unobserved in any other medicine...."

Curiously, however, only within the past 40 years has it been clearly understood that the main value of digitalis is in the treatment of congestive heart failure. Even more recent is the isolation, purification and clinical use of the crystalline glycosides of digitalis, including Digoxin. Most of these can be assayed only biologically, but Digoxin may be assayed physicochemically; this degree of accuracy in standardization ensures uniformity of potency.

Digoxin provides optimal timing of action for oral therapy; prompt onset of effect plus constancy of absorption and a favorable rate of elimination give rapid digitalization followed by even maintenance. Particularly important is the significant margin of safety afforded by the quick subsidence of toxicity (after withdrawing the drug or reducing dosage) in the event of inadvertent overdosage. In emergencies, when an effect is required within minutes, 'Wellcome' brand Digoxin Injection has the practical advantage that it may be given either intramuscularly or intravenously and no prior dilution is necessary.

Digoxin 'B. W. & CO.'®

'TABLOID'® brand Digoxin 0.25 mg. and 0.5 mg., both scored

'Wellcome'® brand Digoxin **INJECTION** 0.5 mg. in 2 cc. ampul

'Wellcome'® brand Digoxin **ELIXIR PEDIATRIC** 0.05 mg. per cc.



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. . . and HP*ACTHAR Gel should be used routinely to minimize adrenal suppression and atrophy in patients treated with prednisone, prednisolone, hydrocortisone and cortisone.

HP*ACTHAR Gel is the most widely used ACTH preparation

*Highly purified

1. Wolfson, W. Q.: Mississippi Valley M. J. 77: 66, 1955.



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**1 provides the antimicrobial
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**2 protects the patient against
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Because it contains Mycostatin (Squibb Nystatin), the first safe antifungal antibiotic, MYSTECLIN acts to prevent monilial overgrowth frequently observed during broad spectrum antibiotic therapy. Manifestations of this overgrowth may include some of the diarrhea and anal pruritus associated with antibiotic therapy, as well as vaginal moniliasis and thrush. On occasion, serious and even fatal infections caused by monilia may occur.

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Supply: Bottles of 12 and 100.

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March 1956, Vol. 2, No. 3

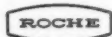
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Noludar® brand of methyprylon
(3,3-diethyl-5-methyl-
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Original Research in
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Perrin H. Long, M.D.



Editor's Page

The Resident and His Patients

IT MIGHT SEEM an unnecessary waste of space to discuss the relationship between the resident and his patients; but many times it has appeared to the Editor that the fundamental goal of medical training, i.e., the care of the patient, is being neglected in our educational programs. This is happening every day, despite the efforts of medical educators to stress the importance of studying "the patient as a whole."

In any ward service, the resident has (or should have) large responsibilities for the care of his patients. Too frequently, because of various factors such as the pressure of work, the types of disease encountered, the personalities and age of the patients and the administrative routine of hospitals, the patient loses his identity as a sick and suffering human being and becomes a *case*. Then we hear "this case has . . ." or, "of ten cases, six were . . ." etc. Actually, in English, the word "case" refers not to the patient as an individual, but rather to a description of sickness or injury, which is best illustrated by the patient's final *case record*.

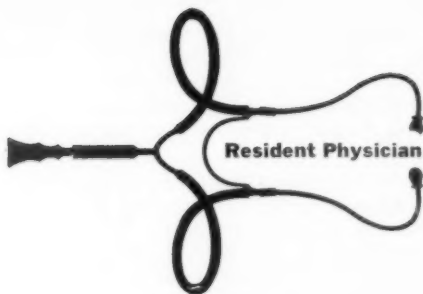
The tendency to substitute, in word and in thought, *case*

for *patient* produces an anonymity of suffering human beings. If we speak of twenty cases, i.e. instances, of coronary disease, all will know what we are talking about, but none will get an idea of who and what the twenty individuals were who unfortunately had this disease. If the resident thinks continually in terms of *cases*, he is losing one of the most important parts of his educational experience with patients.

He must remember that the sick people on his ward are *his* patients. That nothing in the way of thought and effort which he may expend on them can be considered excessive, because these sufferers look to him for relief. Hence, when he accepts them on his ward, he assumes responsibilities which he *cannot delegate*. They and their ills must be constantly in his mind. This point is frequently forgotten by resident physicians when they make arrangements to "be covered" while they trip off for a week-end. Being "covered" does not lessen in any respect the responsibility of the resident for the well-being of the patients on his ward.

With the assumption of responsibility for the medical and surgical care of each patient, the resident physician must accept the added responsibility of developing thoughtful and sympathetic personal relationships with the family, relatives and friends of the patient. All of these groups have greater or lesser interests in the health and welfare of a patient, and they look to the resident as their guide, counselor and source of information. These interpersonal relationships — between patient and doctor and between doctor and the patient's family — should not be avoided or shirked. The resident who accepts them fully will enjoy a stimulating and interesting intellectual and emotional experience, which will best prepare him for his life's work as a physician.

Perrin H. Long.



Physician Placement Agencies

What kind of position might you find through an agency? How about part-time opportunities? What specialties are in the greatest demand? Here's the story obtained through an interview with the director of one of the largest medical placement agencies in the country.

As founder and director of the New York Medical Exchange, Patricia Edgerly is known personally by hundreds of executives in most of America's major industries. Through her good offices, thousands of physicians have found successful locations in private practice, industry or in institutional positions.

Though located in New York City, Pat's placement service, like most others, has no absolute geographic limit.

Q How would you define "medical placement agency"?

A In the broad sense of the term, it is an employment agency. As a clearing house for available openings and for those seeking openings, we screen both parties, evaluate each in terms of the other, and when a "fit" appears probable, notify both parties so that an interview can be arranged. This is done on a fee basis computed according to the salary involved. In this and some

Asked what got her started in her placement service for physicians, Pat, herself a happy combination of warmth, charm, intelligence, and dynamic executive ability, replied candidly:

"I first thought of a physicians placement agency while working in the laboratory of the Marine Hospital here in New York. At about three in the afternoon things would quiet down, the clinics would close and we'd begin to clean up. Usually we'd put a pot of coffee on the bunsen burner and the interns and residents would drop in for coffee and conversation.

"The subject inevitably came around to 'locating.'

"A young doctor would say: 'I'll be leaving the first of the month. . . . I'm broke. . . . I haven't enough to open an office . . . what happens now?' After hearing the same problem repeated hundreds of times, I finally decided to do something about it. I opened an office myself—right here in this building. That was nearly 25 years ago."

Like other medical agency directors throughout the nation, Pat's contacts and experience enable her to evaluate both the job and the man, bring the two together when it appears both will benefit. "The young physician, especially, often feels he has an insurmountable problem—just in getting started. He doesn't know where to turn and has no idea of the many and varied opportunities available to him."

other states this fee is limited by law.

Q Do most of the established medical placement agencies handle other than physician placement?

A Yes. Agencies do differ though. Here we do a great deal of work with physicians. Some agencies do less; some, more. It varies according to the location and the specific agency.

Q What other types of positions do you fill?

A Pharmacologists, pharmaceutical chemists, bio-chemists, medical secretaries, record room librarians, lab technicians, hygienists, medical copywriters, and many pharmaceutical company positions in such things as advertising, market research, sales, promotion, and so forth.

Q Do you place physicians in areas outside of New York-New Jersey?

A The majority of our placements are in this area but we often have occasion to place outside of these states—and overseas, too. I would say we are primarily dealing with the eastern states, though.

Between agencies

Q Is there a national association of physicians' placement agencies?

A No, nor is there any contractual affiliation between agencies. Of course, some of us have established close relationships and personal friendships over the years. We meet at medical society conventions.

Q Would you refer a physician to another agency?

A Certainly. For example, a physician applied with us for location in a territory where we seldom have openings. Shortly after, I met him at the recent AMA convention and suggested to him that he take his application to the head of a Chicago agency who was also at the convention. I knew this Chicago agency had more in that area than we.

Nearest agency

Q Should the physician apply then, to the agency nearest the area in which he wishes to locate?

A Yes. As I mentioned, we often get openings from other states and overseas—but as a general rule, our volume in the West, for example, is not nearly what the West Coast agencies would have.

Q Are most medical placement agencies operated in the same way?

A Generally speaking, yes.

Q What makes an agency successful?

A Reputation and referrals. Our business runs pretty much on reputation. Long-established agencies have developed relationships over the years which continue to bear fruit each year. For example, we may have placed a physician or executive years ago. Perhaps now he is in the employing group. He knows us, is familiar with the way we do business. When he needs an assistant or knows of an opening, he comes back to us.

Ethical consideration

Q What's the major difference in placing a physician as compared to, say, any layman?

A When you deal with physicians, you know and accept the same ethical principles they must live and practice by. There are often very narrow lines of ethical distinction involved in positions which are offered through our agency. We must strictly abide by medicine's ethical considerations in order to stay in business and maintain our reputation. It's as simple as that.

Screening important

Q You refuse, then, to list certain openings?

A Definitely. There are openings we won't even consider. Our business—this applies to all agencies—is a two-way street. We must attempt to put the right man in line with the right job. If we can't keep our batting average up in this respect, we would not be able to continue in business. Thus, we don't take chances with questionable openings.

Q Wouldn't this also mean that you would have to screen, perhaps rejecting, some physicians who apply?

A Of course. And we do. We check the educational background of each applicant, his qualifications, references and other factors. After all, we are seeking to put the physician in touch with an opportunity.

Specialists, locum tenens, groups

Q Are there many calls for a specialist to assist another specialist in private practice?

A Some, yes. But more general practice assistants are called for — logically, since there are more physicians engaged in general practice.

Q How about locum tenens?

A We have many calls for this type of thing. Quite often an older physician wants a man to take over his practice for three months, six months, or longer. This is often because of vacation trips. Unfortunately for the resident, these are not all July to December requests.

Q What is the situation in group practice?

A There is a steady growth in groups, of course. But in the East group practice hasn't attained the popularity enjoyed in the Midwest or Southwest. I have a letter here from a group in New Mexico which requests a pediatrician and an obstetrician. They are still quite scattered. Of course, the future may see the picture change.

Institutions and industry

Q Have you institutional positions available?

A I think our institutional and industrial placement averages about 50% of our total placements of physicians. In other words, about one of every two physicians we are able to place takes an industrial or institutional position. I think, how-

ever, we are rather unique in this respect. As I told you, whenever there is a medical convention and I attend, I always try to have lunch or dinner with some of the other people throughout the country who are in the medical placement field. We discuss our mutual problems and just generally talk shop. Over the years I've gotten the opinion from others that as a percentage of our total placements we here in New York do a lot more in industrial and institutional placements.

Q You do quite a bit of placement with the pharmaceutical manufacturers, don't you? What type of position is open in the pharmaceutical industry?

A There are many. Medical directors, research directors, medical copywriters, professional services. Incidentally, for young physicians who have a background in physiology or pharmacology, the opportunities are limitless. And for the physician who happens to have a Ph.D. besides an M.D., the demand is terrific. Pharmaceutical companies pay excellent salaries. They want top men.

Q Do the pharmaceutical companies particularly want specialists?

A Not all specialties, no. For example, there is little opportunity for the surgeon in most pharmaceutical firms. I do know one or two companies that do have surgeons but these are the exceptions. I think primarily internal medicine is important in most companies.

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Physician

Q How about woman doctors?

A Well, we are always looking for good woman doctors. But there aren't too many because they generally get married and have their family responsibilities. Sometimes they want a part-time job. Generally speaking though, there aren't too many. Quite often, as you know, they practice in conjunction with their husbands. She usually will take the pediatrics or gynecology work regardless of his specialty.

Specialties in demand

Q What specialties would you say are in particular demand at the present time?

A Well, of course, pathology, radiology and anesthesiology are still in great demand. Positions in these specialties pay very well.

Q Are there any positions offered physicians by the insurance companies?

A Yes, quite a few. Some of these are part-time positions, some full-time. Insurance companies often have an employee health program. This is also true of unions and large employers such as the telephone company and big corporations. In insurance companies, too, there are administrative medical positions. For instance, whenever a policy having a large principal amount is to be sold, there is a physician on the staff of the larger life companies who checks the report of the examining physician's physi-

PHARMACEUTICAL
MANUFACTURING COMPANY
PRIVATE PRACTICE
LOCUM TENENS
GROUP PRACTICE
RESEARCH
PART-TIME
OPPORTUNITY



cal examination of the insurance prospect. This administrative physician must pass on that examination, determine whether or not the company should issue insurance coverage for this particular individual.

Q This would be more or less a desk job?

A Yes, strictly a desk job. No personal or patient contact.

Private vs. industrial physician

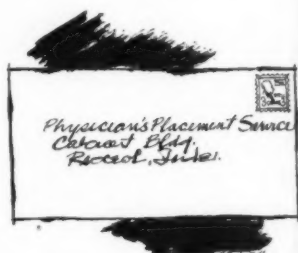
Q Do you find that many physicians who go into health associations, insurance companies, and other corporate ventures often decide they want to go into private practice later?

A Very seldom. The reason I suppose, is that most of them have had a practice previously. Many leave their practices because they find for one thing that their home life is squeezed into a very few hours of the week. Some physicians worry that their wives and families are growing away from them.

In fact, a great majority of industrial positions often stipulate that the physician has had some time in private practice before being considered for the opening. This requirement has a sound basis. Private practice, of course, gives a physician an insight into the practice of medicine. It is, in a sense, a proving ground for many physicians.

Many pharmaceutical firms do not like to take a young doctor who has just finished his residency. On the other hand, they will give the same

doctor careful consideration if he has had even as much as one year in practice. Whether that year was financially successful or not does not concern these companies. They quite logically want someone who has been



in practice and who reacts to the literature which the pharmaceutical companies mail to the physician.

Leaving private practice

Q While we're on the subject, what are some of the other reasons you have found for physicians giving up private practice?

A Well, I have found it is rarely a matter of money alone. In fact, they often take less money to go to one of the industrial jobs. I say, less money but here I mean gross, not net. Actually the take-home is often more. Also they have the security, too. There is usually a pension plan, often participation through stock ownership is available. The doctor who is grossing through private practice perhaps \$16,000 would be taking home \$10,000 or \$11,000.

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An industrial physician pays no office overhead, has no unpaid or uncollectible bills; most physicians in industrial jobs are in excellent shape financially. I've mentioned erratic hours and lack of security in private practice. This comes home particularly to the physician as he approaches middle age. He wants to live a more normal life. He is also thinking of retirement.

Part-time

Q What are the chances for a physician to get a part-time position?

A By-and-large, excellent. We often can work out a plan so that the hours of a part-time job fit in to the beginning practice of the physician's specialty. For example, if a surgeon asks us about part-time openings, we usually tell him it would be better to take an afternoon job, leaving the mornings free for operating. Now, if he happens to be an internist, I suggest that he take a morning job. This leaves his afternoons free for hospital calls and house calls. He can arrange his office hours accordingly.

Q Would this specialist be one who is just beginning a practice?

A Very often. As you know, the beginning practice is often very slow. Frequently there is not enough money coming in to pay the overhead and the payments on new equipment. Until such time as the prac-

tice builds to a break-even point, part-time jobs often provide the solution. We know, of course, that these physicians will only be in these jobs until their practice does grow. The hours are usually 9-12 or 1-5.

Q How many days a week?

A Mostly five days a week. There are some jobs, not too many, where the physician needs to go in three afternoons a week. But ordinarily, a part-time job is 9-12, 1-5, five days a week.

Insurance examiner

Q Do the insurance companies have these part-time jobs?

A As examiners, yes. If the physician wants to become an insurance examiner he lists his name with the company. Then, when there is anybody in the physician's neighborhood who is applying for insurance, the company contacts the doctor and the doctor goes to the home of the insurance applicant.

Q Do they come to you for this listing?

A No, I would advise the beginning specialist to go directly to the insurance company. The physician is usually notified that he has been appointed the company's examiner in that particular neighborhood. Some of the larger companies such as Metropolitan and Equitable welcome applications on the part of physicians who wish to be insurance examiners.

To BE CONTINUED — Part II of this interview will appear in the April issue.

Your Practice Needs Printing

An expert discusses the printing, stationery and bookkeeping needs of the beginning practice, guides you toward a practical and economical selection

Bernard W. Slater

Like it or not, all physicians, GP and Specialist, must run a *business* to maintain a practice. The *business*, of course, is the doctor's office. The office sends bills, pays bills, enters charges, credits payments, reports social security and withholding taxes, buys supplies, files case histories and correspondence and produces case histories and correspondence when needed. The office keeps accounts of the doctor's earnings and expenditures so that on tax reckoning day, income and deductions can be properly integrated into a tax return.

Initially, the doctor may run the office himself. As he becomes pressed for time this function will be

delegated to an employee or, in many instances, to his wife.

But, unless the doctor gets off to a correct start, confusion may give way to chaos as he becomes busier and busier.

Experience during many years of dealing with this aspect of medical practice confirms what Dr. Peters said in a recent "Resident Roundtable:"

"When I opened my office I thought the only problem I'd have would be how to go about finding patients. I did not think that I would have problems once I had found patients. One of the first things that was most difficult for me was the practical business management of

ABOUT THE AUTHOR—Mr. Slater holds an executive position with a leading printing firm which specializes in handling the business needs of physicians. He writes from an extensive background in the specialty printing business.

my specialty. Nobody in my residency ever bothered to give me formal lectures about bookkeeping..." (RESIDENT PHYSICIAN, November, 1955)

The business management of a practice is a strange and novel problem for which most new doctors find themselves inadequately prepared. Bookkeeping is a mystery and the "paper" needs of an office are only vaguely conceived. So it is little wonder that most residents entering private practice could use a little guidance in buying the proper and necessary printed items to get a correctly organized start.

And a correct start is more than half the battle won.

Bookkeeping

So far as bookkeeping is concerned, there is, fortunately, a simple and complete solution to the problem. There are available several ready-printed bookkeeping systems specifically designed for doctors.

These require no bookkeeping knowledge whatsoever.

The headings are in non-technical language. And by entering each transaction day by day under the appropriate heading, the doctor can't help but have a complete and running picture of his earnings, collections and disbursements, both business and personal, deductible and non-deductible. It then becomes a simple matter of arithmetic at the year-end to prepare an accurate, concise tax return affording the doc-

tor all his legally permissible deductions on his cash income.

The price of such a bookkeeping system is so low — under \$10 per year — that there is little reason for starting a practice without one.

In addition to the bookkeeping system there are several other "must" items when opening an office. These are patients' history records, filing cabinet, business cards, letterheads, billheads, envelopes, Rx blanks and, of course, announcements of his entry into practice.

History records

Patients' history records have reached a very high point of development. Ready-printed forms for every specialty are available from several sources in a choice of sizes and shapes to fit the three standard file sizes, namely 5x8 inches, 4x6, and 8½x11 lettersize. The most popular is the 5x8 size, card or folder style. The advantage of the folder style over the card is that it provides twice the writing space but takes no more room in the file drawer. Also, laboratory slips, notes, etc. can be placed within the folder, which thereby acts as an envelope holding all the pertinent records of the case.

Engraved stationery

To the average person, layman or doctor, purchasing printing is a venture into the unfamiliar. Professional stationery can be printed in

either plain (flat) or raised letters. Raised letters can be produced either by the steel plate engraving method or by the plateless engraving method. Steel plate engraving is by far the most costly method. It is considered by many to be a needless and expensive luxury, particularly since plateless engraving has been perfected by specialists to a point that only trained experts can tell it from steel plate engraving—and the cost is about half. The difference in price between flat letter printing and plateless engraving is small so that the choice between these is a matter of taste or preference.

Color

For his professional stationery, the doctor should avoid fancy color schemes. Colored inks and colored papers are fine for milady's perfumed notes but are too informal for a doctor's office. Black ink on white paper is the most dignified, most business-like and, hence, the most widely used combination.

Paper

Stationery papers fall into two general categories: sulphite and rag content. The former is made from wood pulp alone. The latter contains a percentage of rag, which means either rag cuttings or cotton. In each general category there are many types. Sulphite papers are graded 1, 2, 3 and 4. Number 1 is the best. Rag content paper comes

in either 25%, 50%, 75% or 100% rag. The higher the rag content the more costly the paper. However, for the average physician, any percentage above 25% is an unnecessary expense. The writing properties are little, if any, better—and there are no readily discernible or practical differences. The higher rag content papers serve specialized requirements which are not important to the physician user. The most widely used papers for doctors' stationery are the bond finish Number 1 Sulphite and the cockle finish, 25% rag. The bond finish is a smoother, harder surface than the cockle finish on rag paper. Both are excellent in appearance and writing properties. Ask to see samples of each before buying and choose the one you prefer.

One observation here about envelopes might be pertinent. Fine papers are more translucent or transparent than coarser papers. If you prefer more opacity in envelopes used for bills or checks get these in 24 lb., White Wove stock. White Wove is too soft for general writing purposes, but provides the most opaque white envelope.

Card stock

Patient history records are generally furnished in two stocks. The card style is printed on a rather stiff white index card stock. The folder style comes on a more flexible ledger stock, usually buff color. This ledger stock, though not as stiff

as the index, is actually more durable and soil resistant and will look better after continued handling and longer use. The index stock, being stiffer, cracks and dog-ears more readily. Many doctors are not aware of this, being of the mistaken impression that because index is stiffer it is also better.

Purchasing

Printing can be purchased locally or from one of the several mail order printing firms that specialize in doctors' printing on a nation-wide basis. The mail order firms can usually supply all the doctor's needs without requiring the doctor to leave his desk. Not only is this a convenience, but by specializing in this type of printing, these firms enjoy considerable cost economies, which are reflected in their prices.

A comparison of local prices with mail order prices on office staples such as cards, letterheads, Rx blanks, billheads, etc., will show the mail order prices to be from 33% to 75% lower. The leading mail order firms unconditionally guarantee quality and satisfaction.

Quality

Perhaps a word here about quality of printing would be helpful. Wherever the doctor buys, he should determine whether his job will be printed with hand set type or machine cast slugs. Hand set type is used over and over. It is subject to wear and chipping and is harder to

line up for clean, even impressions. Cast slugs are virgin for each job and each letter is perfect and perfectly aligned. The difference in the printed result is readily discernible to anyone. Poorly printed letterheads or bills create the wrong impression and a fine printing job costs no more, frequently less.

Average list

To get an idea of cost, check the list (on page 50) of items needed on opening the average office. Of course, individual needs will vary as to both quantity and items, but the list is sufficiently representative to give a good idea of the price of individual items and the total expenditure involved.

In addition to the listed material there are several miscellaneous items that might total about \$10 or \$15. Among these are *daily visit slips* for recording the data on each house call, *telephone pads*, *inoculation certificates*, *school notes*, etc. However, these are not an initial must and the doctor will quickly learn from experience the additional printed requirements of his own practice. Perusal of a mail order catalogue issued by the specialty printing firms will also furnish much information and help the doctor crystallize his ideas about office procedure and needs. Most of these firms offer free samples to eliminate guesswork about the appearance of the various printed items. Also supplied, with no obligation to the doctor, are

Office Supplies To Start With

Stock Items

Range in prices shown indicates differences in size and style

500 Patients' History Record Forms	\$6 to \$9
500 File Pockets	\$7 to \$9
Two-drawer, Desk Top File	\$12 to \$15
Two Sets Alphabetical Guides	\$3 to \$5
Doctor's Bookkeeping System	\$5 to \$10

Total expenditure for the above items is \$33 to \$48.

Printed To Order Items

	Plain Print	Plateless Engraving
250 Announcements, with plain envelopes	\$8.00	\$9.00
1,000 Professional Cards	4.50	5.50
500 Letterheads, 6¼"x9¼", 25% Rag	5.00	6.00
1,000 Billheads, 25% Rag	6.50	7.50
2,000 Envelopes, 3⅝"x6½", White Wove	14.00	16.00
1,000 Rx Blanks, pads, #1 Sulphite Bond	4.50	—

Total expenditure: \$42.50 (plain) or \$44.00.

bookkeeping instruction sheets with illustrated pages, and printed hints for setting up a doctor's filing system with answers to questions on the general subject of practice management.

Recommended system

The most frequently asked questions concerning management of the physician's office pertain to filing. How do I set up my file system? How do I know whom to bill each month without going through every card, etc. etc.? One company recommends the following filing system.

The "tools" are:

1. A file cabinet (either desk top or standing)
2. Alphabetical guides
3. Folders or pockets to hold all records of each patient and to prevent intermingling.

The file cabinet or drawer should be divided into two sections, as follows:

1. *Active Patients*—for the records of (a) patients who are currently under the doctor's care and (b) patients who owe the doctor money whether or not they are still being treated.

2. *Inactive Patients*—for the records of patients who are not currently being treated and who do not owe the doctor money.

Arrange each file alphabetically with not more than 20 or 25 folders behind each guide. A straight alphabetical guide, one letter per guide, is usually adequate. For larger practices, guides divided into 40-80 or more sub-divisions should be used.

For doctors who keep patients' financial records on a separate set of cards from history records, the above file set-up will be duplicated, one for the history cards and another for the account cards. In

either case, with this filing system, billing each month simply involves pulling out the active file. This eliminates needless effort, saves time and helps avoid losses through oversight.

To sum up, if the doctor has any doubts about the what or how of opening his office, before spending any money he should take advantage of abundant free help that is available, and prevent many difficulties at the beginning.

An incorrect start can cause inconvenience, loss of time, effort and money, and is much harder to rectify at a later date. A correct start will pay immeasurable dividends for years and years.

Bigeminal Pulse?

The two Belfast doctors visited their new patient together, and both put their hands under the bedclothes to feel his pulse. By accident, however, they got hold of each other's hands.

"Nothing serious," said one doctor.

"Probably drunk," said the other.

—*Southern Star*

In the pages which follow, your journal presents a few of the difficulties faced by foreign-born, foreign-educated residents now in training in the United States. Comments of the foreign residents in "Resident Roundtable" and "The Foreign Resident: His Initial Problems" may not be perfectly representative. They are candid and, in a measure, indicative of the thinking of many of these visiting students.



Some have come to learn and return home. Some are here to stay. Their problems have become ours, too. Perhaps some contribution toward their solution may be up to the American-born resident, the attending physician, hospital administration, the specialty boards. Often it is not a question of rules, but simply one of attitude.

The Foreign Resident: His Initial Problems

"Belonging" is the big problem. To be treated as a colleague in medicine is what he'd like. Adaptability must be his strong suit. Learning a bit of "American," helps, too.

Ernesto C. Deza

A Turkish physician revealed to me, "You know, I had to send out eighty applications before I obtained my residency."

"You are lucky, boy," a Korean resident said, "I had to make out one hundred and twenty."

I asked an American citizen: "How many applications did you file?"

"One," he answered.

In trying to secure a residency, the foreign doctor encounters this placement problem—a problem of turning out applications *en masse*. He copes with this alien difficulty willingly and without the benefit of any secretary or bureau. He just keeps on writing and writing until he wears his pen out, and then he

borrows another. For him, centuries pass until the favorable reply.

The foreign resident learns that not all hospitals in the United States are open to him. He may ask himself, with some bitterness, "Is this really a free country with equal opportunities for all?"

In saying this, of course, he is perhaps not being completely fair. Disappointment, not reason, may guide his thought.

In many cases, the foreign resident comes here as a United Nations Exchange Visitor. Consequently, he experiences difficulty in accepting readily the answer of many hospitals, "Sorry, wait until you get your citizenship and maybe we will consider you for employment."

ABOUT THE AUTHOR—Dr. Deza is Philippine-born, bred, and educated. A graduate in medicine of the University of Santo Tomas, Manila, in 1951, Dr. Deza is here as a resident to qualify for his boards in psychiatry.

Many hospitals do not even bother to answer.

Acceptance

A letter of acceptance in an accredited hospital may come. Often, it insures the foreign resident of acceptance as an intra-venous injector only. In some places, he fits in only as a spare part of machinery.

If he is noticed as a person, he may encounter an iron rank of old-timer nurses and attendants who firmly believe that *they*, not he, should be the doctor.

An attending physician may ask him: "Where do you come from? Aha! Malaria country." The foreign resident could (but of course, shouldn't) retort: "Yes. And now I am in Polio country." Such an exchange of observations can result only in making the foreign resident feel more inadequate and unwanted. Retorts are usually best left unretorted.

The foreign resident may expect too much from his new associates. He may have a good working knowledge of the writers, leaders, and many of the wonders of this country. He usually is eager to learn more about the greatness of America. Instead, he is asked by an American resident: "Do you have this Smith's apparatus in your country or do you just use your teeth?"

Insecure

Being in a strange and new environment, the foreign resident feels

highly insecure. Questions and treatment such as above may make him feel more inferior. He sometimes becomes over-sensitive, takes everything said to him in the wrong way. He misinterprets. Little things may quickly mobilize his anxiety which he counters with a defense of silence or over-attachment to his work. Usually, these defenses won't suffice. Feeling even more unwanted, more insecure, he finds himself in a vicious cycle.

What should he do? Be a stoic? A martyr, a monkey, or a robot? At any rate, he has a wide variety of choice. . . . If he stays.

If he prefers the easy way out, he can take the next boat home. Precisely, in this manner, a German resident reacted recently. After a year of residency, he confided to me that he felt sick and he went back to his parents in old Germany. No guts? Maybe.

Ex-GIs help

Some American fellow-residents, especially those who have been in the service, do not aggravate the foreign resident's difficulty in satisfying his want to be accepted and respected as a person. They go out of their way to treat the foreign resident as a colleague, without condescension. They try to keep up on the latest foreign news items, share their interests with the foreign resident, discuss with him his country. Pressed with this attention, the foreign resident agrees happily to the smartness

of the United States over all nations.

In one hospital, the authorities scheduled each foreign resident to take turns every week in speaking on "Medical Practice In My Country." A markedly subtle and effective as well as fruitful demonstration of acceptance. Feeling important and that they "belonged," it is needless to affirm that every foreign resident worked with more motivation and efficiency.

Communication

If the foreign resident and his new co-workers were in love, they could well dispense with speech. Being in America, the foreign resident, in order to ventilate, to obtain a patient's history, or to curse and not be misinterpreted as singing praises, has to learn to speak "American." Strangely enough, this "language barrier" may not be a handicap necessarily.

The special brand of English the foreign resident uses may actually accelerate his acceptance by making him sound "cute." Or it can make faces red—his or others. For example, instead of asking, "How old are you?" a Spanish resident delivered this query after a painful labor, "How much are you?"

Luckily, his young female patient was much too ill to take offense.

At another time, he asked, "Are you your mother's daughter?"

A Cuban resident discovered a convenient pass-word. Nurses would

ask him routinely many times, "Doctor, what shall we do to this patient?" The Cuban would reply knowingly and solemnly: "X-ray." Visitors of patients would inquire: "Doctor, do you think my baby will be all right?" Invariably he would announce: "X-ray." He got by with this; gradually he substituted a longer answer, good for all occasions: "Fine, fine, fine!" He still uses this.

During his first days in this country, a Mexican resident employed a different pass-word. Slang and idiomatic lovers among the natives would ask him: "Did you get out of bed on the wrong side?" He would answer, "Very well, thank you."

To prevent murdering the language thus creating international incidents, the foreign resident may arrange night courses in English with a high school. Or, he may simply wind his stethoscope around an English-Turkish or English-Italian pocket dictionary. The foreign resident may also learn either a nasal or a drawling English by the simple (sometimes) expedient of dating an American girl. He can take his girl friend sightseeing, heading for the farthest place possible, so he can pick up more vocabulary per mile. Never mind the gas.

Training

The foreign resident has to see to it that he gets his training in an accredited hospital with an exchange program, for this is a prerequisite

to his visa approval. He selects by himself, by trial and error, the hospital, mostly blindly. At times he may land in a hospital where he does not get a proper or fair orientation into his duties and privileges. Because of this he may make mistakes which could easily have been avoided.

In many instances, the original goal of the foreign resident is a medical center. But, the surrounding reality of living may turn his head, make him materialistic. Hence, he sometimes sacrifices a good or enviable training for a minimal one; the former offer stipends not too tempting, while the latter spells easier living and training, better remuneration.

Perhaps the foreign resident may over-compensate for his home deprivations and austerity. This could be his excuse for succumbing to materialistic convenience with but only a slight twisting of his arm necessary. He rationalizes, "I am modernized and Americanized."

He at first fails to see that "Americanized" and "modernized" do not have their true meanings in "materialism."

Orientation

Considering the variant or contrasting polarities of the Anglo-Saxon, the Latin, and the Oriental mentalities, the foreign resident may require remarkably fluid powers of adaptation to get an adequate orientation.

To be able to conclude that not all American faces look alike and that "Joe" is not a welcome name, may require time and suffering.

He may need also to take stock of himself, to understand the cause of his tensions and to discharge his tensions more maturely. This, in order to work more happily.

More than the techniques of his specialized branch, he may need to learn and to accept that his own intolerance and hostility may be the weakness, and the source of some of his problems of adjustment. He will learn that "belonging," "communication," and "orientation," are problems which he can help solve through his own healthy attitudes.

"Why am I in America, specializing in this field?" The foreign resident may well ask himself profitably: "Is it a means or an end?"

His answer may make him happy or it may not.

Ophthalmology Board Exam

The 1956 *practical* examination of the American Board of Ophthalmology will be held in San Francisco, Calif., June 18-22, and in St. Louis, Mo., October 20-24.

Applications for the *written* examination, to be held in 25 cities in the U. S. and in large military establishments on January 20, 1957, must be filed *before June 30, 1956*.

Resident Roundtable

Discussion among residents from Canada, Iran, Argentina, and the U.S. brings out a few problems—and some suggestions too.

Resident Roundtable is a transcript of a recorded panel discussion among five residents and specialists, each from a different hospital. This and succeeding Roundtable articles represent the ideas, comment and opinion developed by the panel in response to questions raised by the moderator.

Actual names of those attending the Resident Roundtable are not used. You are invited to contribute to these Roundtables through your Letters to the Editor.

MODERATOR: Dr. Grundy, as a Canadian citizen and graduate of a Canadian medical school, did you have any problems with your residency in the U.S.?

DR. GRUNDY: I think the greatest problem was having to write the national boards. In two countries connected as closely as Canada and the United States, I think it is ridiculous to have to write the exams all over again. Our method of studying in Canada, the subjects studied and the contents of these subjects are exactly the same as in the U.S. It isn't one-sided, though. Going to Canada you have the same problem presenting itself to American graduates. I think there should be a closer alliance—enough at least, so that practically the same exam doesn't have to be repeated.

MODERATOR: May I interpose. I gather that you passed licensing board exams in Canada . . .

DR. GRUNDY: . . . That's right . . .

MODERATOR: . . . Which were similar to our national board . . . You feel it was a duplication to take the national boards in America?

DR. GRUNDY: Yes, I do.

MODERATOR: Are any medical schools in Canada unapproved as far as the American national board exams are concerned?

DR. GRUNDY: No. All graduates of medical schools in Canada are accepted for national boards here.

MODERATOR: Did you have any difficulty in getting a residency in America?

DR. GRUNDY: No, I didn't.

MODERATOR: How many applications did you write?

DR. GRUNDY: One.

MODERATOR: Do you notice any difference in training between the U.S. and Canadian hospitals?

DR. GRUNDY: No. Nothing that I have observed thus far.

MODERATOR: Dr. Aboudi, you were educated in Iran?

DR. ABOUDI: Yes. At the Teheran University Medical School. I also interned in Teheran.

MODERATOR: Did you practice in Iran?

DR. ABOUDI: Yes, I practiced for three years.

MODERATOR: What would you consider the biggest problem you faced connected with your U.S. residency?

DR. ABOUDI: The biggest problem was to find a residency. Though having less difficulty than many of my colleagues from Iran, I applied to ten hospitals before being accepted.

MODERATOR: Have you had any difficulty with the language?

DR. ABOUDI: Not particularly. I had a fine training in English while in a missionary school in Iran. One problem was rather frustrating, though. Some hospitals asked me to get a license in their states before applying for residency. Unfortunately, to take a license, you must have three or four years of postgraduate work, or two years of residency. I couldn't get a residency without license and couldn't get a license without residency.

MODERATOR: Do you think there might be a solution to help the foreign graduate in this problem?

DR. ABOUDI: Well, I think a clearing house of information, some organization to which the foreign doctors could write, would help. Somebody who knows the rules and regulations of all the states, also, a list of hospitals willing to accept foreign graduates. That would be of considerable help.

MODERATOR: Why did you come to the U.S. for your residency?

DR. ABOUDI: I am like many. I left my country to come here for an advanced education in a nation which is the world's teacher. I would like to be a good specialist. My country needs better specialists to do the teaching. Everybody has some desire to do something better.





This month's panel—

MODERATOR: Graduated from a west coast medical school and took his internship and residency in surgery at a west coast university-connected hospital. He then served as a medical officer in the Navy and at present is completing his training in a surgical subspecialty at a large university hospital.

DR. PAZ: A graduate of an Argentine medical school, she served her internship in a university hospital in Buenos Aires. At present she is an assistant resident in obstetrics and gynecology in a voluntary hospital.

DR. GRUNDY: A graduate of a Canadian medical school, he took his internship in Canada and one year of residency in medicine at a municipal hospital in the states. At present he is taking his second year of medicine at a voluntary hospital.

DR. ABOUDI: After graduating from an Iranian medical school, he took his internship and a period of private practice in Iran. At present he is a first year resident in pediatrics in a voluntary hospital in the U.S.



MODERATOR: Are there two types of foreign graduates then, those who come here to stay permanently, and others who only come here for a couple of years of post-graduate training?

DR. ABOUDI: I think there is just the second type to begin with. However, once here, the admiration of America grows on you.

MODERATOR: Being perfectly frank, how do the American born residents treat you?

DR. ABOUDI: They are usually friendly, cooperative, and, often without meaning to be, condescending.

MODERATOR: What about your attending staff of the hospital?

DR. ABOUDI: They cooperate. Some with a resigned attitude of making the best of a bad situation, others with a friendly professional understanding.

MODERATOR: And what about patients?

DR. ABOUDI: I've had no difficulty there. I can speak and understand English. I am able to talk to the patients, take their histories and so forth.

MODERATOR: Do you think that perhaps there may be any resentment that a foreign graduate has taken a good residency where the American graduate failed to get it? Have you ever felt that?

DR. ABOUDI: You mean do they prefer American residents? Yes, they do. And quite naturally, of course.

MODERATOR: Dr. Paz, you are from Argentina and attended medical school in Buenos Aires?

DR. PAZ: Yes, I also had my internship in Argentina.

MODERATOR: Is this your first U.S. hospital?

DR. PAZ: Yes, that's right. I applied at 37 hospitals.

MODERATOR: Why so many?

DR. PAZ: Probably the time of year when I came was not the right time for getting an appointment. The language difficulty was also a great disadvantage. As a foreign graduate, and a woman applying for ob gyn residency, I suppose this didn't make it easier for me. Finally, I got this appointment. And I am very happy at having it.

MODERATOR: May I ask you what was the biggest problem you faced?

DR. PAZ: Well, at the beginning, getting the residency appointment was the biggest difficulty. I thought I knew some English when I came. But I did not. I had a lot of help from American doctors and American residents . . . they were very patient with me and they helped me until I got over that period.

MODERATOR: Are you in touch with any of your countrymen who are residents in other U.S. hospitals?

DR. PAZ: Yes. We correspond regularly. They are as happy here as I am. Some of them found it difficult to adjust because



of the difficulty of customs, language and everything, but they are doing pretty well.

MODERATOR: Do your patients accept you?

DR. PAZ: Yes.

DR. ABOUDI: They often tell us when they appreciate the work we do for them and we sometimes get nice cards from them. They are quite appreciative.

MODERATOR: Is there any comparison between American residency training and specialty training in your country?

DR. GRUNDY: In Canada, I would say, it is very similar.

DR. ABOUDI: There are many differences in Iran.

DR. PAZ: I think residents here have more patient responsibility than at home.

DR. ABOUDI: Yes, they are less a student over here. They get more authority; they can do much more.

MODERATOR: Are residencies organized in the same way?

DR. PAZ: In Argentina it is set-up differently. Once you have finished medical school and internship, you are allowed to go into private practice.

MODERATOR: You have no licensing examination?

DR. PAZ: No special examination. Nothing like your state examinations. Once you have passed the 32 subjects in the 7-year medical school program you are allowed to start in private practice. If you want to go into the teaching profession, to become a professor at the university, then you must continue special courses and present a research thesis after one year of experience in a new field.

MODERATOR: Coming back to your residency here now,

do you think that your education has been respected by American doctors?

DR. PAZ: Yes, it has been respected. Some of my friends have found some difficulty with their fellow residents. But not with the patients and not with the attendings.

MODERATOR: In what way?

DR. PAZ: In the way that they feel a little underestimated. I know that they try hard to make friends among their American fellows, but that is sort of difficult. For some reason, probably the difference in education and customs. But this is a problem whose solution requires understanding and time.

MODERATOR: Dr. Aboudi said he felt problems for all foreign residents were the same. Do you agree?

DR. PAZ: No. There is a big question between the foreign graduate who is coming here for training for a couple of years and then goes back home. His main difficulty is language or maybe making friends or maybe getting into an approved hospital, something like that. Now, for the people who are going to stay permanently, then the great problem arises: how to get a license. That is the biggest part of the problem for them.

MODERATOR: Do you know of any place that you could write to, finding out just where you can get a license or do you have to write to each individual state one at a time?

DR. PAZ: Nothing is static in licensure. You may be eligible and probably by the time you write there are changes. You are no longer eligible. Some states have requirements which are



impossible to fulfill by anybody, like for instance, have your legal home in that particular state at the time you matriculate from medical school. How can a foreign graduate in medical school in South America be a legal resident of a state here? This leaves all foreign-educated physicians out.

MODERATOR: Did you know about this licensing problem before you left Buenos Aires?

DR. PAZ: No, I didn't at all. Otherwise I would have thought twice before coming. Even though this is the best country in the world for better medicine.

MODERATOR: Dr. Aboudi, did you know of the licensing problem before you came here?

DR. ABOUDI: I did not know the problem. I had friends who came to America. They wrote me, but by the time I came here the situation was completely different. Often, because of your need for interns here, foreign students are accepted with open arms—but if they decide they'd like to stay, then they meet with the problems.

MODERATOR: What of other requirements?

DR. PAZ: You can pass an examination if you have a good enough background, as the American doctor. But the requirements include all those things that are so difficult to get from your medical school and your high school; papers from the other places you have been working before. Especially coming from a place like Argentina that is now in the middle of a revolution every day. It is hard to get from the university and the high schools the papers they ask you for here.

DR. ABOUDI: Going back 8-15 years for papers is sometimes impossible. Records of such things as your term examination grades are seldom kept so long.

MODERATOR: We'd better call a halt here, because of the time. Thank you all for your cooperation. The best of luck in your residencies.

By Robert P. McCombs, M.D.



Guest Editorial

Coordinated Training Programs

THE CHOICE of a hospital for internship or residency training is influenced by many factors including familiarity with a hospital, its prestige, the type of service, the teaching program, the location, the stipend, and in some cases the final decision may be based upon an appraisal of the amount of responsibility apt to be granted the house staff in the case of patients.

Certainly some, and preferably graded, responsibility is desirable. An ideal program is one in which the amount of supervision is exactly that necessary to prevent mistakes, and no more. The most competent house officers are able to assume responsibility quite rapidly, but others should be granted this privilege somewhat more slowly. Unfortunately, too few hospitals have the facilities, staff, and expert organization necessary to develop ideal training programs.

In some, but certainly not all, hospitals of the "city"



Robert P. McCombs

Director, Postgraduate
Education, Tufts
School of Medicine;
Senior Physician,
New England
Medical Center

or "community" types responsibility for important decisions regarding patient care is granted too early in the training program with the result that serious errors in patient care sometimes occur. Some young physicians are attracted to these hospitals in order to gain "practical" experience. Unfortunately, they do not always recognize their mistakes and may develop faulty methods, which then are apt to plague them throughout their medical careers. On the other hand, in some hospitals of the "university" type with staffs that are chiefly full-time, the training program may suffer because of a failure to delegate sufficient responsibility when ability warrants it.

Prospective interns and residents often recognize these deficiencies in training programs and attempt to overcome them by moving from one hospital to another. There is much to be said in favor of this because of the broadening influence of seeing medicine from different vantage points. On the other hand, because of lack of integration in such a selected program, proper grading of responsibility in relation to previous experience and ability is rarely achieved.

Centrally coordinated training programs between several hospitals of different types are being developed in various areas. When the benefits of "university," "city," and "community" type hospitals are combined and graded responsibility added, the ideal program each young physician seeks is being approached.

New England Medical Center

NEW ENGLAND CENTER HOSPITAL
PRATT DIAGNOSTIC CLINIC
FARNSWORTH SURGICAL BUILDING
ZISKIND RESEARCH
BUILDING

TUFT UNIV
of MEDICINE

BOSTON
DISPENSARY

BOSTON FLOATING HOSPITAL



Fifth of a series on resident centers

TUFTS UNIVERSITY SCHOOLS
OF MEDICINE & DENTISTRY

POSNER HALL
RESIDENCE



Some 35,000 patients from Greater Boston, the six-state New England area, the rest of the country and the world are treated annually at Boston's New England Medical Center.

Located in downtown Boston, two blocks south and west of historic Boston Common, three hospitals and Tufts University School of Medicine combine their staffs and facilities to form an integrated medical center which is rapidly becoming one of the best known and most highly respected of its type in the East.

In 1929, Tufts Medical School, established in 1893, joined with the Boston Dispensary and the Boston Floating Hospital to form the nucleus of the New England Medical Center. The Dispensary, oldest single unit of the Center and third oldest medical charity in the country, was established in 1796. The Boston Floating Hospital, once a specially equipped hospital ship which



took sick children from the city's congested areas into the fresh air of Boston Harbor for care and treatment, was built in 1927 as part of the far-sighted plan for the Medical Center.

Combined facilities

The original affiliation was the first in a series of steps toward the modern concept of a teaching-treatment center which combines a school of medicine with adjoining general and specialized hospital facilities. The growth toward this goal has been rapid.

In 1938, the Pratt Diagnostic Clinic and Hospital was built as an addition to the Center. Ten years later the 150-bed Farnsworth Surgical unit was built and incorporated with the Pratt facilities into the new New England Center Hospital. In 1949, a seven-story building adjacent to the new hospital was acquired; named the Ziskind Research Laboratories, it was equipped to house expanding research activities.

Much of the Center's growth was supported by another New England Medical Center affiliate, the Bingham Associates Fund. Established in 1932 by William Bingham II who

Getting ready for a "Grand Rounds" closed circuit telecast to 50 cities. Here, participating physicians in the auditorium of the New England Medical Center confer with producer, director technicians and lighting experts prior to going "on the air."



was interested in better medical care on a regional basis, the Fund supports medical and hospital education through extension programs at the New England Medical Center. In addition, it sends medical, paramedical, and hospital personnel into affiliated hospitals and medical groups as an educational aid to better medical care.

Other activities of the expanding Center include its recently instituted

(first issue, January, 1955) quarterly publication, *Bulletin of Tufts-New England Medical Center*.

Services

All pediatric services are in the Boston Floating Hospital; adult medical, surgical and diagnostic in-patient services are located in the New England Center Hospital; and some 32 out-patient clinics and a rehabilitation center, for which a new five-

The 32 clinics of the historic but modern Boston Dispensary unit are busy places.



aces.



story building will be built this year, are maintained in the Boston Dispensary.

Supervising these integrated hospital facilities is an attending staff of more than 50 full-time physicians. Each holds a teaching appointment at Tufts. The active intern, resident and fellowship program under their supervision now includes a house staff of 100. Within the medical specialties are 10 interns, 12 residents, 11 assistant residents, and 20 fellows. The surgical services have 11 residents, 12 assistant residents, and 5 interns. The pediatric service has 8 residents. The remaining 11 house staff members are working in neurology, neurosurgery, and psychiatry. An additional residence

To supplement the facilities at the New England Medical Center, and to give its doctors-in-training experience in varied surroundings and under varied conditions, the Center provides rotating affiliations with other accredited hospitals. Included in this group of teaching affiliates are such centers as the Shortell Fracture unit at the Boston City Hospital; the Boston Veterans Administration Hospital for other special types of surgery; the Eastern Maine General Hospital in Bangor.



Assignment: E



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★ INDICATIONS:

Beta-hemolytic streptococci:	Diseases of the respiratory tract, meningitis, erysipelas, cellulitis, rheumatic fever (both onset and recurrence)
Pneumococci:	Pneumonia, meningitis
Staphylococci:	Often implicated in diseases of the meninges, lungs, bone, endocardium, skin
Gonococci:	Diseases of the eye, urethra, joints
Pseudomonas aeruginosa and Escherichia coli:	Diseases of the urinary tract
Haemophilus influenzae:	Laryngotracheobronchitis, pneumonia
Shigella, Salmonella, and coliform organisms:	Causing certain types of bacillary enteritis

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In both the mixed and the undiagnosed infection, BICILLIN-SULFAS broadens your therapeutic resources. It offers two *kinds* of antibacterial action—antibiotic *and* chemotherapeutic. Together, the two mechanisms provide decisive control over a wide range of gram-positive and gram-negative infections. BICILLIN-SULFAS combines BICILLIN, the penicillin that ensures its own absorption, and SULFOSE®, the triple sulfonamide for maximal action and renal safety.

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Typical nurses' station in Farnsworth Surgical wing of the Center Hospital.

Maine, for both medical and surgical emergency work; the Burbank Memorial Hospital in Fitchburg, Massachusetts, for mixed surgery; the Central Maine General Hospital in Lewiston, Maine, for additional medical work; the Joseph P. Kennedy Memorial Home for polio and chronic neurological diseases; the Boston Lying-In Hospital for obstetrical anesthesia; and the Pondville State Hospital for x-ray therapy.

Laboratories

Research laboratories at the New England Medical Center also offer the teaching program a wide latitude in all fields. Assistant residents in

medicine, for example, spend six months of one year in specialties which may include hematology under Dr. William Dameshek; neurology, Dr. John F. Sullivan; radiology, Dr. Alice Ettinger; metabolism, Dr. William B. Schwartz; cardiology, Dr. Samuel Proger and Dr. Heinz Magendantz; and endocrinology under Dr. Edwin B. Astwood. Also housed and available in the Center's research areas are Dr. Freddy Homburger's Cancer Research unit, Dr. H. Edward MacMahon's pathology projects, Dr. George W. Mitchell's cytology laboratory, and the large and active clinical laboratories which serve the entire center.

Conferences, rounds, lectures

Rounding out the formal teaching program are daily teaching conferences with senior staff physicians.

Modern facilities help residents provide better medical care, get top training.



In addition, departmental teaching conferences are on a regularly scheduled curriculum. Both medical and surgical grand rounds are included together with guest lectures and visits from the area's outstanding physicians in every medical and surgical specialty.

"No intern and resident program should make so many demands upon the time of their doctors so as to leave them little or no time for study on their own, an opportunity to

write their own papers, or to attend lectures, conferences or professional meetings in some of the other outstanding hospitals in the area," according to Dr. Robert P. McCombs, senior physician and director of post-graduate education at Tufts.

"We feel that our ratio of attending staff and hospital beds to interns and residents is ideally suited to provide both a broad experience and an active educational program."

The most recent annual figures

Floating Hospital residents examine child. Dr. I. S. Hurwitz (left), Dr. Richard Wagner, Tufts Clinical Professor; Drs. Daniel Dorman and Irving Koretsky.





The busy operating room schedule and specialized surgery in the Center Hospital unit makes the observation towers a focal point of interest for residents and interns.

compiled at the New England Medical Center clearly indicate this effective ratio, as well as point up the types of patients seen during an average year.

Patients

Medical in-patients treated at the New England Center Hospital numbered 4,014, while surgical patients totaled 2,027. Included in the latter group were 224 urological, 239 orthopedic, 262 neurosurgical, 320 gynecological, and 923 general surgical procedures. In addition, 1,682 patients were seen in 5,598 visits in

the private ambulatory Pratt Diagnostic Clinic of the Hospital.

The 32 clinics of the Boston Dispensary, treating low-income outpatients, cared for some 14,200 patients during the past year and the growing Rehabilitation Institute treated a total of more than 1,500 patients in this same period.

In the pediatric services of the Floating Hospital, a total of 2,299 patients were admitted under the care of Physician-in-Chief James Marvin Baty, his assistant Dr. Marshall B. Kreidberg, and Surgeon-in-Chief Dr. Orvar Swenson.

Other special clinics and services, such as the new Cleft Palate Institute of Tufts University School of Dental Medicine, attract additional numbers of patients to the Center.

Because the staffs of each of the units are integrated, and the services of each supplement the others, a wide range of specialized treatment is available. This, added to the high caliber of physicians in each specialty, gives the resident excellent experience in either a general field, or nearly any specialty of his choosing.

Resident accommodations

The New England Medical Center offers the resident maintenance in a new, house officer's dormitory on the Medical Center campus. Opened in 1954, Posner Hall provides private, well-furnished accommodations for each house officer as well as parking facilities. The building also has recreation facilities, a snack bar, a library and a television room. The same building houses Tufts medical and dental students, but, recognizing that the needs and requirements of students and house officers differ,

The New England Medical Center provides residents with a continuing program of conferences and lectures as a regularly scheduled feature of their training.





Annual "get acquainted" buffet follows arrival of new residents and interns. Above, Richard T. Viguers, administrator, (left) introduces residents Leonard A. Burgin and G. Kieth Tutton to Dr. Arthur A. Thibodeau, Chief Orthopedic Surgeon, and Dr. Bertram Selverstone, Neurosurgeon-in-Chief. At right, enjoying snack bar, are Miss Barbara Sherman and Drs. William Hayden, Stuart L. Scheiner and Jerry Aurbach.



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TYPICAL MONTHLY CONFERENCE SCHEDULE AT THE NEW ENGLAND CENTER HOSPITAL

TIME	WEEK	MONDAY
12-1	1,3	Metabolism Conference (Dr. Schwartz)
12-1	1	Pediatric Clin. Path. Conf. (Drs. MacMahon and Baty)
12-1	2	Medical Conference
12-1	3	Pediatric Medical-Surgical Rounds (Drs. Baty and Swenson)
12-1	4	Medical-Pathologic Conference
7-9	1,2,4	Pathology Conference (Dr. MacMahon and staff)

TUESDAY

12-1	1	Clin. Path. Conf. (Drs. Patterson, MacMahon and guest)
12-1	2,4	Endocrine Conference (Dr. Astwood)
4-5:30	weekly	Anesthesia Conference (Dr. Etsten)

WEDNESDAY

12-1	weekly	Neurology, Neurosurgery and Psychiatry Conf. (Drs. Sullivan, B. Selverstone and Hope)
4-5	weekly	Surgical Pathology (Dr. MacMahon)
4:30-6	alternate weeks	Physiology and Biological Chemistry seminar

THURSDAY

12-1	weekly	Guest Lecturer
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FRIDAY

1-3	weekly	Combined Medical-Surgical Grand Rounds
4-6	2,4	X-ray Conference (Dr. Sosman)

SATURDAY

8-9	weekly	Anesthesia Conference (Dr. Etsten)
11-12	weekly	Hematology Conference (Dr. Dameshek)

both facilities were constructed as separate units.

In accordance with established policy, surgical and anesthesia residents are required to live "in." Residents in medicine are offered the alternative of full maintenance or an equivalent amount of money monthly. A room is maintained in Posner Hall for the resident "on call" if he lives outside the campus.

House staff program

An excellent house staff-Medical Center relationship has been developed during the past several years. This has resulted in such projects as a week-long orientation program, active support of the house officer's association, continued and close cooperation among the administration, the staff and the house officers themselves. It has also provided for a special educational secretary whose exclusive responsibility is to the house staff.

Educational secretary

The secretary's job starts with the doctor's first acceptance into the resident program and follows him through his entire appointment. The educational secretary establishes contact with the newly named appointees and also keeps in touch with past residents and interns. All correspondence, queries and information are channeled through her office by both the administration and the medical staff. This unique service was established to give the house

staff the best possible opportunity for help in the complex of details connected with residency appointments and training.

Orientation

The New England Medical Center administration and staff works to integrate the resident as a part of the hospital family. Residents are helped to an understanding of the inner workings of the hospital beyond those areas in which they are occupied. Part of this program is accomplished on a personal level between attendings and residents in the hospital. Another part of the program is the result of a formal schedule of orientation lectures which is held over a four day period in early July for all new residents.

The first day's schedule consists of a general discussion of the hospital's services. Speakers include the administrator, the dean of the Tufts University Medical School, chiefs of medicine and surgery, director of the blood bank, and the president of the house officers association.

On the second day, nursing gets the spotlight. Also up for discussion are such para-medical services as medical records, business services, admitting, and administration. The third session takes up diagnostic facilities of the hospital and also the social service department. The final day of orientation is centered around a discussion of the Center's clinical departments.

New England Medical Center

Residency	Chief of Service	Residencies (years)				Length of Program (yrs.)
		1st	2nd	3rd	4th	Total
Internal Medicine	Samuel Proger	5	8	12	16	41
Neurological Surgery*	Bertram Selverstone	1	1	1	1	4
Neurology*	John F. Sullivan	2	2	1	—	5
Psychiatry*	Justin Hope	1	1	—	—	2
General Surgery	Arthur A. Thibodeau	4	4	3	2	13
Urology	Burdick G. Clarke	—	1	1	1	3
Anesthesia	Benjamin Etsten	3	3	—	—	6
Pathology	H. Edward MacMahon	—	2	—	2	4
Radiology	Alice Ettinger	1	1	1	—	3
Pediatrics	James Marvin Baty	4	4	—	—	8
Nursing Service						
Administration	Hazel Keith, R.N.	Oct.-May each year				1
Hospital Administration	Richard T. Viguers	July-June each year				2

*Fellowships available in these specialties plus:

Gastroenterology—Malcolm Stanley	Arthritis—Heinrich Brugsch
Endocrinology—Edwin B. Astwood	Hematology—William Dameshek
Metabolism—William B. Schwartz, Jr.	Cardiology—Heinz Magandantz

Each resident is issued a house staff manual containing a summary of rules, procedures and policies in the treatment care of patients at the New England Medical Center. A multitude of the necessary details involved in the operation of a large medical center are thus available in a convenient form for ready reference by residents.

Working wives

House officers' wives who are graduate nurses or who have medical or secretarial skills are encouraged to work in the hospital. In addition, they are offered every assistance in finding suitable housing within their means.

Health

The health of the intern and resident is considered of primary importance. Each doctor is given a complete physical examination on arrival. This includes not only a chest x-ray, but complete laboratory work and examination. The procedure is repeated at intervals during and prior to completion of his appointment.

Off duty

Boston's central position in the early years of our nation's development has made the city something of a storehouse of historical landmarks and architecture. And much of the city's interest to the visitor and its temporary and permanent residents

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lies in the many evidences of pre- and post-revolutionary America. Most of these have been carefully preserved and maintained even as the modern Boston grew up around them.

The resident who looks for "outside" education while at the New England Medical Center will find that his free time can be devoted to a broad variety of pursuits. Within the greater Boston area are some of the nation's finest hospitals and universities which offer year-round programs to stimulate and educate. Recreation, too, is offered at nearby beaches during the summer months, ski slopes in the winter, major

league baseball, basketball, and hockey. Six universities (Tufts, Harvard, Boston College, Boston University, Mass. Inst. of Tech., North-eastern) field teams in the major and minor sports in intercollegiate competition. Inexpensive relaxation is available: sailing rented boats on the Charles River or sitting along its banks in the evening at an outdoor concert of the Boston Pops Orchestra conducted by Arthur Fiedler. At a small expense, the legitimate theatre, the movies, or the world-famous Boston Symphony Orchestra are available for an evening's entertainment.



"Well, you know nothing about medicine!!"

Clinico—Pathological Conference

New England Center Hospital

History

A 66-year-old woman was admitted to the New England Center Hospital because of left shoulder pain, weakness and loss of weight. Though her health had been generally good, she had had a mild cough for many years. During the four months prior to admission, the cough became more severe and was productive of moderate amounts of thick white sputum. In the same period, her appetite decreased markedly, and she had frequent nausea and sometimes vomiting after eating. Her weight decreased from 120 to 97 pounds. In the two to three months before admission, she had sharp pain in the left upper anterior thorax radiating

to the scapula and made worse by coughing and inspiration. She also had marked weakness and dyspnea on exertion.

The patient had been hospitalized for scarlet fever at the age of 21 but had had no other serious illnesses. She had known of hypertension for five years and had smoked from 10 to 12 cigarettes daily for 40 years.

Examination

Physical—Her temperature was 99.4 F, pulse 120, respirations 24, and blood pressure 210/80. She was a small, undernourished woman who was alert and cooperative, but coughed frequently and became dyspneic on slight exertion. Her skin was

THIS MONTH'S CONFERENCE was prepared by H. Edward MacMahon, M.D., New England Center Hospital, Professor of Pathology, Tufts University School of Medicine; Louis A. Selverstone, M.D., Pratt Diagnostic Clinic—New England Center Hospital, Assistant Professor of Medicine, Tufts University School of Medicine; and James F. Patterson, M.D., Pratt Diagnostic Clinic—New England Center Hospital, Assistant Professor of Medicine, Tufts University School of Medicine.

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pale and dry, and her tongue smooth, shiny and red. There was slight clubbing of the fingers. Examination of the chest revealed a dorsal kyphosis and decreased expansion of the left side on inspiration. There were dullness to percussion and absent breath sounds over the left thorax and scattered moist inspiratory rales were heard at the right lung base and left apex. The heart was not enlarged, but there was a Grade II blowing systolic murmur along the left sternal border. In the abdomen there was tubular pulsating mass about 5 cm. in diameter extending from the epigastrium to below the umbilicus; over this was heard a harsh systolic murmur. The dorsalis pedis pulsations were not felt but posterior tibial pulsations were faintly palpable and other pulses were normal. There were no other significant abnormalities.

Laboratory Studies—On admission the laboratory findings were as follows: hemoglobin 11.0 gm./100 cc.; hematocrit 35%; leukocyte count 25,000 (73% polymorphonuclears, 10% bands, 15% lymphocytes, 2% monocytes); platelets and red blood cells normal; sedimentation rate 104 mm./hour (Westergren). Fasting blood sugar 78 mg.%; blood urea nitrogen 13 mg.%; total serum protein 5.8 gm.% (albumin 2.4, globulin 3.4); serum Hinton and Kahn negative. Urinalyses: maximum specific gravity 1.021; negative tests for sugar; 0 to 0.01 gm.% albumin; sediment 2 to 8 leukocytes, and 0 to

15 erythrocytes per high power field. Stool guaiac negative; blood culture *A. aerogenes*; urine and sputum cultures no growth. Sputum cytologic study unsatisfactory.

X-ray Studies — The chest film showed uniform opacity of the entire left side of the thorax, though lung markings could be seen through the opacity. On lateral films there was diffuse opacity of the left upper lobe and scattered densities in the left lower lobe. The right lung and the heart appeared normal. An abdominal film showed three small round calcifications in the right upper quadrant, but no other abnormalities. Films of the spine, pelvis, and skull were negative. An electrocardiogram showed left ventricular hypertrophy.

Course

Penicillin and streptomycin were given by injection and fever, which was present on the first two days, subsided. On the 5th hospital day, bronchoscopy revealed a questionable weakness of the left vocal cord, partial fixation of the carina, and stenosis and elevation and fixation of the left main bronchus. The patient apparently tolerated the procedure well, but two days later, while being transferred to the surgical service, she complained of numbness and coldness of the legs. Her blood pressure rapidly fell to zero and she became cyanotic. Administration of intravenous norepinephrine resulted in a rise of blood pressure,

and her left lower extremity became warm and flushed but the right remained pale and cold. All pulses, including the femoral, were absent in the right lower extremity but were normal on the left. Later, the abdomen was noted to be protuberant, there was tenderness in the right lower quadrant, and an ecchymosis on the right flank area. Blood pressure was maintained with difficulty and she died 8 hours later.

Discussion

DR. SELVERSTONE: Consideration of patient's problem seems to divide logically into three sections: the nature of her chronic pulmonary disease, the etiology of the pulsating abdominal mass, and finally, the cause of the terminal vascular collapse. I do not believe that I can explain the entire picture with one diagnosis.

We are given a wealth of clinical data concerning the nature of the chronic pulmonary disease, and the situation appears fairly clear. I find it difficult to avoid the diagnosis of a large lung abscess in the left upper lobe, secondary to an obstructing bronchiogenic carcinoma. The patient had smoked a half pack of cigarettes a day for 40 years, a fact that we are reluctantly forced to accept as of etiologic importance in pulmonary cancer, particularly in women since the disease occurs less frequently in this sex. Approximately four months prior to admission she began to go downhill very rapidly,

with an increasing productive cough, severe anorexia, nausea, vomiting and a weight loss of 23 pounds. There was weakness, dyspnea, and pleuritic pain over the left upper anterior chest, strongly pointing toward involvement of the left upper lobe. Few pulmonary diseases, including cancer, can cause such rapid progression unless there is associated suppuration.

The physical examination confirmed the fact that the major disease was in the left lung, though on the physical signs given one cannot decide between fluid, atelectasis, and consolidation in the left chest.

The clubbing of the fingers is of interest, but only confirms the fact that there is chronic pulmonary disease. This sign, caused by overgrowth of the soft tissue of the finger tips, is of entirely unknown cause and may develop with almost explosive violence in lung abscess, in pulmonary carcinoma, and in chronic pulmonary infection. It is relatively unusual, however, in pulmonary tuberculosis.

Laboratory studies confirmed the existence of a serious infection, with a leukocytosis of 25,400 with a marked shift to the left and a blood culture positive for *A. aerogenes*. This gram-negative bacillus is a common secondary invader in chronic lung infection, and is often found in the sputum of patients with bronchiectasis and lung abscess. In this case the culture showed no growth, but I should wonder whether

or not the culture had been obtained before she received antibiotics. Since *A. aerogenes* is also a common organism in urinary tract infections it is of interest to find here that the urine culture was negative. In view of the history, the marked leukocytosis, and the fact that the patient was febrile after admission, responding to therapy with penicillin and streptomycin, there seems little doubt that she actually had an *A. aerogenes* septicemia and that the positive blood culture did not represent contamination. The only obvious source for this septicemia is, of course, the pulmonary disease.

The x-ray studies of the chest showed diffuse opacity of the left upper lobe and scattered densities in the lower lobe. The involvement of the upper lobe alone can explain the "uniform opacity of the entire left side of the thorax" on the AP view, since the interlobar septum between upper and lower lobes on the left is a very oblique one, and the left lower lobe descends almost to the diaphragm anteriorly. The absence of mediastinal shift and of pleural fluid is negative information of value in eliminating empyema as a possible cause of the symptomatology. Uniform density of a pulmonary lobe usually indicates pneumonic consolidation, in the absence of atelectasis, and here there is no tracheal shift or elevation of the left diaphragm. However, simple lobar pneumonia cannot logically be the cause of the entire picture and we

must assume that the infection is secondary to underlying disease in this lobe. The densities in the lower lobe may be metastases or patches of bronchopneumonia, the latter being most likely.

Bronchoscopy revealed the classic picture associated with bronchiogenic carcinoma, except for an actual description of the tumor itself. The weakness of the left vocal cord suggests involvement of the left recurrent laryngeal nerve somewhere on its long path down and around the aortic arch and back to the neck, a common finding in cancer of the left lung. Fixation of the carina and elevation and fixation of the left bronchus suggests involvement of the subcarinal nodes, and is often accepted as strong evidence of inoperability. The bronchial stenosis, which most probably was carcinomatous, provides the element of obstruction so necessary for the development of a pulmonary abscess behind it, and is a further link in the diagnostic chain. Undoubtedly biopsy and cytologic studies were done, which probably revealed cancer of the bronchus.

In a consideration of the pulmonary disease, I am hard put to suggest a plausible differential diagnosis, since the evidence of bronchiogenic carcinoma of the left upper lobe with secondary abscess formation, leading to *A. aerogenes* septicemia, is so overwhelming. Lung abscess on a non-carcinomatous should be considered, but is quite rare in

an upper lobe, and there is no history of preceding dental work or nose and throat surgery which might lead to aspiration of a foreign body into the bronchial tree. Bronchial stenosis on an inflammatory basis does occur, but is usually secondary to pulmonary tuberculosis, for which there is little evidence here. Unresolved pneumonia with secondary abscess formation is a possibility but does not explain the bronchoscopic picture.

The second major problem is the nature of the tubular, pulsating mass, in the abdomen. This is obviously a vascular structure, and the differential diagnosis lies between a palpable abdominal aorta and an aneurysm of the abdominal aorta. No other information is given to help us except a negative abdominal x-ray, the three right upper quadrant calcifications probably representing gallstones.

Aneurysm of the abdominal aorta is a serious and often fatal disease. These aneurysms are almost all arteriosclerotic in etiology, occur in males almost six times as frequently as in females, and generally are found in patients over 50 or 60 years of age. They almost never begin above the origin of renal arteries, but may be so large and the aorta so tortuous that they may be felt in the upper abdomen on occasion. If diagnosis is not made and treatment, which consists of surgical resection and aortic grafting, carried out, approximately half rupture in

the course of a year or two, with sudden death.

The symptoms of abdominal aneurysm prior to rupture are few, but patients may have backache or left flank pain, symptoms of which this patient did not complain. About two out of three patients do have a palpable, pulsatile abdominal mass, such as this patient presented. On physical examination, differentiation from an elongated but not aneurysmal aorta may be possible. Two questions are important — whether or not the pulsations are expansible, allowing us to delineate a definite aneurysmal mass, and whether or not the structure is tender. Elongated aortas are rarely tender, while aneurysms frequently are tender to palpation from distention of the adventitia. This information is not given us here. A final diagnostic point is the x-ray demonstration of calcification in the walls of an abdominal aneurysm—diagnostic if present. However, since it is present in only about a third of the cases, the absence of calcification certainly does not exclude the diagnosis.

At the time of transfer to the surgical service the terminal catastrophe occurred. The sequence suggests intra-abdominal hemorrhage, probably from rupture of an abdominal aneurysm. This diagnosis could explain the sudden collapse of the blood pressure, the abdominal distention and tenderness, and the appearance of the right flank ecchymosis. Rupture of an abdominal aneurysm is

often fairly slow, with an oblique tear through the adventitia which may partially thrombose, and sudden death does not necessarily occur. To explain the sudden occlusion of flow into the right extremity, one might speculate that the aneurysm extended down to the iliac bifurcation in such a way that thrombosis of the right iliac artery occurred following sudden collapse of intra-aortic pressure. Alternatively, the aneurysm might have contained a mural thrombus, a portion of which might have become detached and lodged itself as an embolus in the right iliac artery following aneurysmal rupture.

Against this explanation of the terminal collapse is the fact that arteriosclerotic aneurysms, when they rupture, usually rupture retroperitoneally into the left flank, with severe left flank pain. Intraperitoneal rupture is rare, but does sometimes occur.

An alternative possibility is dissecting aneurysm of the abdominal aorta, with dissection past the mouth of the right iliac artery. This could explain the vascular collapse, the deficient circulation in the right leg, and the right flank ecchymosis following external rupture. It is, however, excessively rare for dissecting aneurysms to occur in the abdominal aorta, and when they occur they are almost invariably accompanied by severe tearing pain at the site of dissection. Since the vascular collapse in this patient was quite painless,

and since there is highly suggestive evidence that the patient did indeed have an abdominal aneurysm, I favor the former possibility.

Clinical Diagnoses: (1) *Bronchiogenic carcinoma, left upper lobe, with secondary lung abscess and pneumonitis, left upper lobe, with A. aerogenes septicemia.* (2) *Arteriosclerotic aneurysm of abdominal aorta, with terminal intraperitoneal rupture and right iliac artery thrombosis.*

Pathology

DR. MACMAHON: The autopsy revealed many interesting diseases, the combination of which produced a complex picture both in the clinic and at the autopsy table. There was an epidermoid carcinoma in the upper lobe of the left lung, complicated by infection, abscess formation and signs of septicemia. The aorta was the seat of an extreme form of arteriosclerosis together with extensive fresh mural thrombosis that led to very recent embolic occlusion of the right iliac artery. The stomach and small intestine showed paralytic ileus and beginning peritonitis. Other significant findings included severe coronary sclerosis with remote myocardial infarction, hypertensive hypertrophy of the heart, vascular atrophy of the right kidney and compensatory hypertrophy of the left.

The lung tumor was very large and occupied at least a third of the left upper lobe and a great portion

of it was in a state of liquefaction necrosis. This tumor apparently began in a medium-sized bronchus well back in the lung parenchyma, compressed and completely obliterated the lumina of the large primary bronchus and corresponding vein, and severely constricted the adjacent branch of the pulmonary artery serving that lobe. The tumor did not extend to the hilus and apart from a solitary metastasis into a regional hilar node, there was no evidence of dissemination into any other part of the body. There was a moderately severe bronchitis throughout both lungs, and the tumor and adjoining lung tissue distal to the bronchial obstruction were involved in a chronic suppurative inflammatory reaction with massive abscess formation. Smears and cultures from this abscess showed a mixed infection including *A. aerogenes*. Evidence of septicemia was found in the spleen, liver, lymph nodes and bone marrow, and in the aortic thrombi where bacterial colonies lay well below the surface fibrin. The right iliac artery, already partially constricted by far advanced arteriosclerosis, was completely obstructed by a massive fresh embolus that could easily be lifted from the lumen. The source of this embolus was clearly the wall of the aorta, portions of which were still coated by coarse patches of crumbling, shaggy, mixed thrombi. There was no true aneurysm in any part of the aorta, yet it must be admitted that the entire vessel was inelastic,

was dilated and was tortuous.

The paralytic ileus of stomach and intestine proved to be related to acute infarction of these organs complicated by acute inflammation. The coeliac and superior mesenteric arteries that supply this segment of the alimentary tract took origin from the aorta in their usual positions, and a very careful search failed to reveal any point of complete occlusion in the lumen of either vessel. However, the ostium of each of these arteries was reduced to a pinpoint opening as the result of the atherosclerosis of the aorta.

The coronary arteries were severely sclerosed and narrowed, and at one point, just 1.0 cm. from its orifice, the right coronary artery was calcified and obstructed. The myocardium distally was the seat of a large scar occupying much of the posterior wall of the left ventricle. The cerebral arteries in striking contrast to the coronaries and aorta were surprisingly free of disease.

The hypertensive hypertrophy of the left ventricle manifested itself by increased weight of the heart (500 grams) and, in spite of considerable dilatation of the left ventricle, by an increase in the thickness of the muscular wall. The atrophy of the right kidney was associated with atherosclerotic narrowing of the ostium of the right renal artery. Microscopically, however, both kidneys showed well advanced arterio and arteriolosclerosis, but on the right, which was the side of the

smaller kidney, the lobar and arcuate arteries were considerably smaller by measurement than those on the left. The tubules of the smaller kidney also showed signs consistent with diminished functional activity.

Anatomically one sees in the autopsy findings of this patient the accumulation of four basic categories of disease namely,—(1) cancer, (2) sepsis, (3) arteriosclerosis with its complications of hypoxia, thrombosis, embolism and infarction, and (4) the pattern of long standing hypertension. The first of these is of interest in having reached such proportions without evidence of distal metastasis,—a finding that could be related to compression of the pulmonary vein. The lung abscess was apparently the septic focus that ultimately led to septicemia and here again the occlusion of the pulmonary vein draining the area of suppuration may have been important in preventing embolic bacterial metastasis with secondary abscess formation. The atherosclerosis in this patient was extreme, but as is so often the case, it was not uniformly distributed throughout the body. Perhaps as important as the arteriosclerosis of the aorta itself was, its encroachment into the ostia of the coeliac, superior mesenteric and right renal arteries. In the aorta this change in the intima abetted by sepsis, had created a condition favorable to mural thrombosis, and it was this latter condition that led to sudden embolic occlusion of the right iliac

artery and subsequent ischemia of the right lower extremity. Furthermore, it would appear that this sudden embolism had been the initiating factor in the shock and fall in blood pressure that was experienced by the patient as she was being transferred by stretcher from one service to another. Finally, it was the fall in pressure that led to fatal hypoxia of both stomach and small intestine, and this in turn led to paralytic ileus, infarction necrosis and terminal peritonitis.

Pathologic Diagnoses: (1) Epidermoid carcinoma of bronchus of left upper lobe of lung with secondary abscess formation and aerogenes septicemia due to Aerobacter aerogenes. (2) Arteriosclerosis of aorta, severe with mural thrombosis and embolic occlusion of right iliac artery.

Summary

A 66-year-old woman was admitted to the hospital with a four month history of cough, left upper chest pain, anorexia and weight loss. Examination disclosed evidence of consolidation in the left upper lung lobe and a pulsating tubular mass in the upper abdomen. There was fever and leukocytosis, and blood cultures grew *A. aerogenes*. On the 6th hospital day there was sudden onset of shock, evidence of vascular occlusion to the right lower extremity and death.

The discussor felt that the pulmonary findings were best explained by a carcinoma in the left upper

lung lobe with abscess formation and A. aerogenes septicemia secondary to this. The terminal event was felt to be the result of intraperitoneal rupture of an arteriosclerotic aneurysm of the abdominal aorta and a right iliac artery thrombosis though it was pointed out that these aneurysms usually rupture retroperitoneally into the left flank and that

it is sometimes difficult to differentiate an aneurysm from an elongated tortuous aorta.

Autopsy confirmed the discussor's first diagnosis, but the final event proved to be an embolic occlusion of the right iliac artery arising from a large mural thrombus in a severely arteriosclerotic aorta rather than rupture of an aortic aneurysm.

The Goals of Graduate Training in Surgery

Henry W. Mayo, Jr. of the Department of Surgery, Medical College of South Carolina, writing in the Journal of the South Carolina Medical Association [51:72 (1955)], considers the objectives of residency training under several headings, some of which are 1) *Development of Operative Technique*—This is acquired by assisting a trained surgeon, then gradually taking over increasingly difficult operative procedure. 2) *Increase in Knowledge of Ancillary Fields*—A course in pathology, including tissue examination, an ability to interpret roentgenograms, and a detailed knowledge of gross anatomy are primarily important. Physiology and biochemistry enter the field of clinical surgery. 3) *Attention to Detail*—The resident should personally supervise preoperative and postoperative care. 4) *Record*—Adequate histories, operative notes, and progress reports are an essential part of training. 5) *Results of Surgery*—Reading, and attendance at follow-up clinics which show the results of the work of others. 6) *Development of Surgical Conscience*—Subordinate all considerations to the actual needs of the patient. 7) *Administrative*—As senior resident, be able to direct a large surgical service.

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*Youngblood, V. H.: J. Urol. 70:926, 1953.

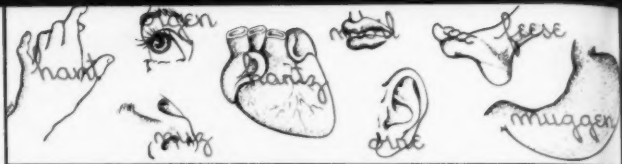
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r also is always pronounced gutturally.

g is always pronounced hard, as *g* in *go*, *get*, *great*.

Anatomical terms

head	—	cup	lungs	—	loongen
eyes	—	oigen	shoulders	—	ahxel
ears	—	oiren	back	—	pleytzes
nose	—	nuz	arm	—	orm
mouth	—	moil	hands	—	hant
teeth	—	tzayner	bladder	—	blahzer
tongue	—	tzoong	leg	—	bine
throat	—	gorgle	feet	—	feese
finger	—	finger	stomach	—	muggen
neck	—	haldz	rectum	}	— tooches
chest	—	broost	buttocks		
heart	—	harts	womb	—	gabarmooter

Courtesy phrases

Note: Mr., Mrs., and Miss (in their English form) are to be used, but normal courtesy also requires the use of the name after the title, if it is known. If the name is not known, the title is best omitted.

Good morning	goot morgen
Good afternoon	gooten tug
Good night	goote nahcht
Please sit down	bitte saitzen see seech
How are you	vee gait ess
Very well, thanks	ah dunk
Do you understand	varstait eer
I understand	eech varstay
Excuse me	enshooldigd
Very good	sair goot
Today	haint
Tomorrow	morgen
Yesterday	gestern

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Directions to patient

do as I do
relax
relax more
open your mouth
open your eyes
breathe deeply
breathe through your mouth
hold your breath
push
cough
please don't move

too vee *eech* too
zite ruhig
zite mahr ruhig
affent eere moil
affent eere oigen
ahtemt teef
ahtemt *doorch* eere moil
hult eere ahtem
kvetch
hoost
bi'te hahlten see still

General questions

do you feel sick
do you have pain
—much pain
—mild pain
where
here
when
how many years
how many days
how many hours
how many times
where were you born
how old are you

een zint krank
es toot *oich* vey
ah sahch veytog
ah bissel veytog
a-voo
duh
van
veeheel yurin
veeheel tag
veeheel shtoondeh
veeheel mohl
voo zint eer geboiren
vee ohlt zint eer

Diseases

measles
scarlet fever
chicken pox
small pox
pneumonia
typhoid fever
enteritis
U.R.I.


muzlen
scarlatina
heener pocken
steln pocken
loongen entzeending
teephoos
kishke entzeending
cult

Systemic inquiry

Head

trauma
unconscious
did you faint

voond
gechalisht
hut eer gechalisht



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of inflammation*

intramuscular

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are you dizzy

headache

Eyes

clear vision

near

far

Ears

he is deaf

noise in the ears

Nose

coryza

did you have a nosebleed

Throat

do you have frequent sore-throat

es shveendelt oich

cupvaitig

eer zaite klor

nunt

vait

air ees toib

sih kleengt een dee oiren

dee nuz rinnt

gagongin blutt fen nuz

hut eer oft haldz shmarzen

Pediatrics

did you have trouble with the
child's delivery

how are the child's stools

—constipated

—diarrhea

—how many a day

does the child eat well

any vomiting

does the child turn blue

does the child seem tired

does it hurt

it won't hurt

it will be over in a minute

do you want a piece of candy

did you take the temperature

what was the temperature

what a beautiful little girl

what a big, handsome boy

baby

good

hut eer gehut shvarikait meet dee
keend's geboort

wee ees de keend's shtoolgahng

—hart

—loysen muggen

—veeheel een ain tag

duse de keend ass goot

bracht de keend

weerd de keend bloy

ees de keend farmattert

toot ass vey

ass werd neecht vey tun

ass weerd zain ariber een ain minoot

veelst dah ah shteekeerl chokolat

hut eer genoomen de temperature

vus ees de temperature

see ees a shane madel

air ees a shaner ingel

klain keend

goot

Genito-urinary

urine

do you get up at night to urinate

does it burn

chills

fever

vasser

shtate eer uf ba nahcht tzeeh lussen vasser

brennt ess

kalt

heetz

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Gastro-intestinal

do you have a good appetite
do you have a poor appetite
are you nauseated
were you nauseated
do you vomit
do you have diarrhea
are you constipated
did you have a B.M. today
feces
black
white
yellow
brown
bloody
do you have cramps
after meals
before meals
did you have a laxative
did you take castor-oil

hut eer ah gooten appetet
hut eer ah shlackten appetet
feelt eer vee tzee brachen
hut eer gafeelt vee tzee brachen
bracht eer
hut eer ah loysen muggen
hut eer ah harten muggen
hut eer gahut eere shtoolgahng haint
shtoolgahng
shvartz
vice
gail
brone
bluttick
hut eer krahmpfen
nuch dam assen
aider dam assen
hut err ganummen ah opferung
hut eer ganummen reetzen oil

Cardio-respiratory

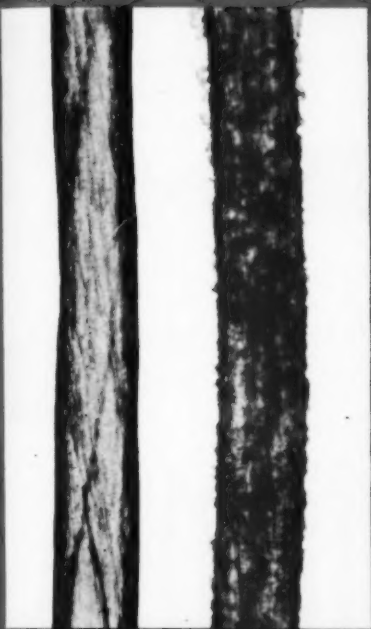
do you tire easily
are you short of breath
does your heart beat fast
do your feet swell
do you have a pain in the chest
—sharp pain
—dull pain
do you cough
do you spit
sputum
bloody sputum
have you lost weight
does someone in your family
have a cough

vart eer meed shnall
hut eer koorzen ahtem
klupt eer harts shnall
vayren dee feece gashvollen
hut eer veytog in broost
—sharf veytog
—neesht sharf
eer hoost
eer shpit
shpyecht
bluttickeh shpyecht
hut eer farloyren vug
hut aymeetzer een eere
familia ah hoost

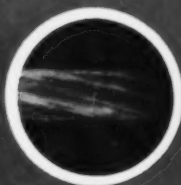
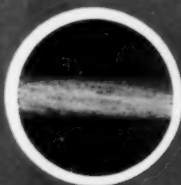
Obstetrics and gynecology

at what age did you begin to
menstruate
how many days do you flow
1 to 10

vee alt gakreegen das monatleeche
krahnhkhait
veefeel tag bluttekht eer
ains, zwai, drai, feer, finef, sachs,
seeben ahcht, nun, zane



Photomicrography
shows why
D & G gut
is stronger—
more flexible



D & G gut

Photomicrograph* shows smooth surface of D & G SURGICAL GUT with no fraying or roughness. The soft matte finish prevents knots from slipping. No grinding to size. Full natural strength is preserved.

Another leading gut

Photomicrograph* detects surface fraying and roughness. This gut was ground to size. It appears uniform to the naked eye, but the powerful camera lens shows imperfections which may cause weakness when a knot is tied.

*Medium Chromic gut, 5-0; light field method; 80 x

D & G gut

Photomicrograph** shows firm, even cohesion of plies—twisted into strands before chromicizing—for greater flexibility. Natural collagen firmly bonds the plies—holds the twist. This results in greater knot strength under stress.

Another leading gut

Photomicrograph** detects separate plies in this gut. Here each ply was chromicized before twisting into suture strand. This process limits natural bonding—lowers flexibility and tensile strength—encourages fraying.

**Medium chromic gut, 00; dark field method; 21 x

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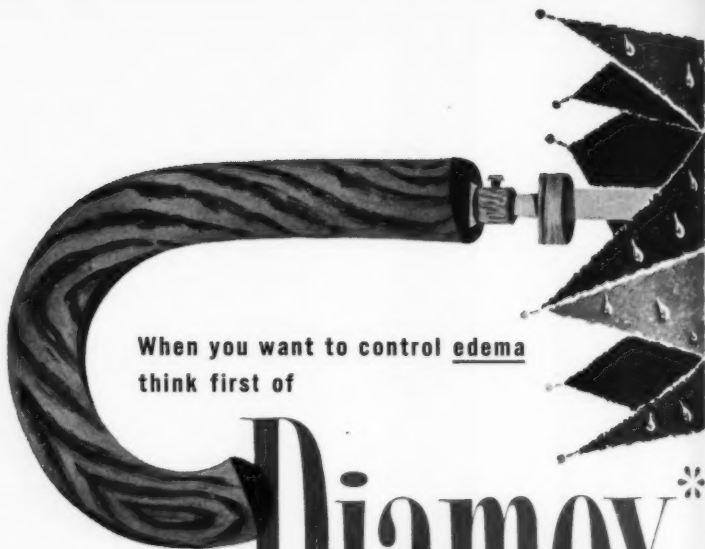


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do you have a discharge
when was your last menstrual period

are you pregnant
do you have pains with your periods

how many times have you been
pregnant

how many children have you had
how much did the largest weigh
what was the duration of labor

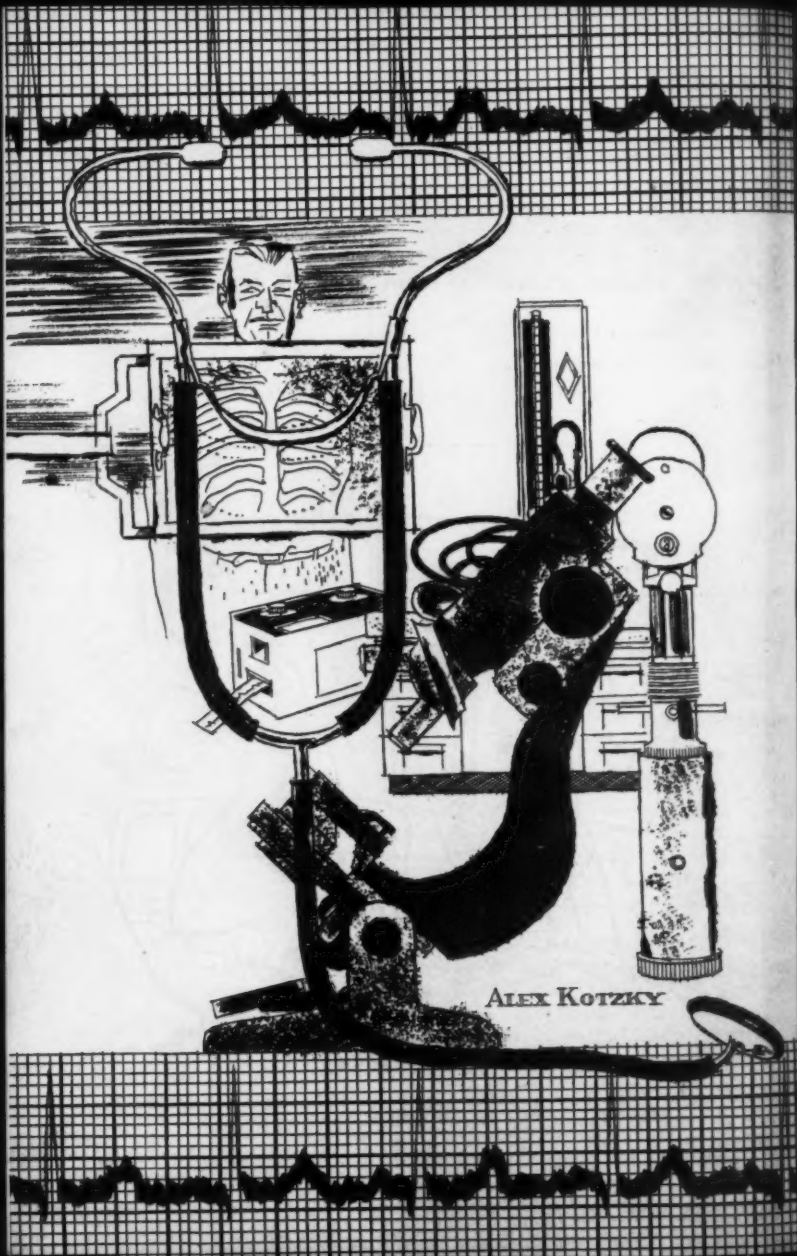
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"As I see it your main problem now is to build up his confidence in himself—his wife ran off with an ape, you know."

Pederle

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Internal Medicine Board Requirements

The American Board of Internal Medicine was established in 1936 by joint action of the section on the practice of medicine of the American Medical Association, and the board of regents of the American College of Physicians. The Board consists of twelve members, seven nominated by the American College of Physicians and five by the section on internal medicine of the American Medical Association.

Purpose of the Board

The major object of the Board is to pass judgment on the competence of internists who desire certification by a representative group of their colleagues — and not to determine who shall or shall not practice internal medicine as a specialty.

Requirements for admission General:

1. All candidates must be citizens of the United States or Canada.
2. All candidates must present evidence of satisfactory moral and ethical standing in the medical profession.

Knowing exactly what's required often prevents confusion and costly misunderstandings. Here are essential facts for quick review. When your particular specialty appears, mark the cover and binding of the issue for ready reference.

The information contained in this article was obtained through direct correspondence with the specialty board. Current news such as changes in requirements, special announcements, and notices of date and place of examination will be published in *Resident Physician* as received from the various boards.

Professional:

1. Graduation from a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association at the date of graduation.
2. Satisfactory completion of an approved internship of not less than twelve months.
3. Residency or fellowship in internal medicine approved by the Council on Medical Education and

Hospitals of the American Medical Association.

This may be done according to the following plan (Plan A) or alternate plans discussed below.

Plan A

A residency or fellowship in internal medicine for a period of not less than three years in a hospital or other institution, approved by the Council for a residency or fellowship in internal medicine. In addition, two years of adequate clinical experience in the practice of internal medicine following the period of graduate study is required.

The Board will accept the following equivalents as satisfying one year of the three years of residency or fellowship to which this plan refers. Two years of the residency must be in the field of general internal medicine.

a) If twelve months of a two-year approved internship in a hospital approved for residency training in internal medicine is limited to the medical service, then the second twelve months may be counted as the first year of assistant residency in medicine. If this course is elected then the remaining two years of residency training must be in the general field of internal medicine.

b) One year of approved residency in one of the following medical specialties: allergy, cardiovascular disease, gastroenterology, hematology, pulmonary diseases, neurol-

ogy, pediatrics, psychiatry, dermatology and syphilology.

c) One year of approved residency in pathology.

d) One year as a graduate student or as an instructor in an approved medical school on a full time basis in bacteriology, biochemistry, pathology, pharmacology, physiology, or internal medicine.

e) An advanced degree in the medical sciences provided the work has been done and a degree obtained after graduation from medical school.

Special note

Graduate training credit for time involved will be allowed candidates who satisfactorily complete post-graduate courses in internal medicine or the basic medical sciences provided by accredited medical schools on a full time basis. This does not apply to courses of less than three months or more than twelve months duration. A certification of creditable performance will be required.

Alternate plans

The Board believes that *Plan A*, that is, an extensive training period of three years, offers the best opportunity for the young physician to prepare himself to meet the responsibilities of a specialist in internal medicine.

The Board has liberalized its eligibility requirements for admission to examination by accepting

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these reinforcing ribs...which
assure the uniform distention
so necessary for proper reten-
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Butiserpine includes the outstanding, complementary drugs:

RESERPINE (0.1 mg.)

relieves tension and produces a moderate hypotensive effect.

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acts on the higher cortical centers to produce mild "intermediate" sedation. May be administered over prolonged periods without hazard of accumulation associated with other barbiturates such as phenobarbital.¹

BUTISERPINE will be found most useful in:

Mild to moderate hypertension; coronary occlusion; angina pectoris, congestive heart failure; anxiety and tension states and for the premenstrual and menopausal syndromes. May be used in conjunction with more potent hypotensive agents when indicated.

Tablets Butiserpine, bottles of 100 and 1000.

1. Butler T. C.; Mahaffee, C., and Waddell, W. J.; Phenobarbital: Studies of Elimination, Accumulation, Tolerance, and Dosage Schedules, J. Pharmacol. & Exper. Therap. 111:425 (Aug.) 1954.

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LABORATORIES, INC.
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half time formal training, and the practice of internal medicine under circumstances favorable as to professional and hospital contacts, in lieu of part of the full time requirements. By this means, exceptional individuals may acquire a knowledge of medicine and experience in its application sufficient to qualify for examination.

a) In all instances one year of approved internship and one year of approved residency will be required, except as indicated under Plan G. The graduate training credit of one year heretofore granted as a result of active duty as a commissioned officer in the armed forces during the period beginning December 7, 1941, and ending January 1, 1947, and during the Korean emergency beginning June 1, 1950, and ending July 1, 1954, may not be applied in satisfaction of the one year of approved residency referred to in plans D, E, and F unless the candidate's assignment is considered by the Board to have been equivalent to an approved residency.

b) Following one year of internship and two years of approved residency, the remaining requirements may be satisfied by:

Plan B. Two years of half time formal training followed by two years of practice limited to internal medicine, or by

Plan C. Five years of practice limited to internal medicine.

c) Following one year of internship and one year of approved resi-

dency, the remaining requirements may be satisfied by:

Plan D. Four years of half time formal training followed by two years of practice limited to internal medicine, or by

Plan E. Two years of half time formal training followed by five years of practice limited to internal medicine, or by

Plan F. Eight years of practice limited to internal medicine.

Plan G. Physicians who have practiced internal medicine for twelve years following an approved internship may qualify for the examination without further training.

Half time (four hours a day, six days a week) formal training under expanded plans B, D, and E is defined as follows:

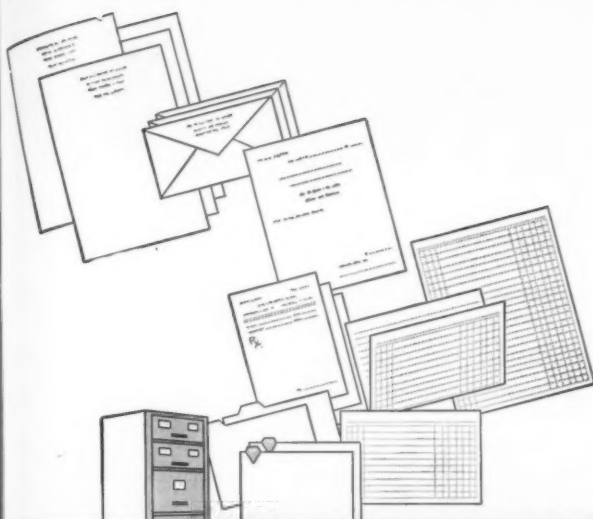
1. Half time as an instructor in clinical medicine in a recognized medical school in the United States or Canada.

2. Half time in a research fellowship sponsored by a recognized medical school in the United States or Canada.

3. Half time as a graduate student in an approved medical school in the United States or Canada.

Practice requirements

A period of not less than two years (to be completed by the time of the first written examination) of adequate clinical experience in the practice of internal medicine. This requirement may be satisfied by independent practice or in associa-



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tion with a recognized internist following completion of formal training.

Graduates of foreign medical schools

All candidates who are graduates of foreign medical schools must meet the following requirements as a minimum:

a) The physician must be a citizen of the United States.

b) The physician must furnish proof that he has graduated from a medical school after completing a four-year full time course in medicine.

c) They physician must have a license to practice in one or more states of the United States, and have been in active practice confined to internal medicine within the state of legal residence for at least two years.

d) Graduates of foreign medical schools prior to 1930 may qualify under the alternate plans of the Board the same as graduates of approved medical schools in the United States.

e) Graduates of foreign schools in 1930 and thereafter must, in addi-

tion to all other requirements, qualify under Plan A. If, however, their school of graduation is "recognized" by the Council on Medical Education and Hospitals of the American Medical Association, they may qualify under the various plans of the Board the same as graduates of approved medical schools in the United States.

Preceptor training

Preceptor type training is not recognized in satisfaction of any part of the three year requirement of formal graduate training.

Armed forces credit

a) Active duty as a commissioned officer in the Medical Corps prior to January 1, 1947, may be applied as one year of residency credit or one year of practice credit, regardless of assignment. Service beyond one year may only be applied as practice credit on the certification of former chiefs of service that assignments were in the field of internal medicine on a full time basis in the care of clinical patients largely on one's own responsibility.

b) Active duty as a commissioned



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each  **small** OPTILET contains:

Vitamin A	7.5 mg. (25,000 units)
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Riboflavin	5 mg.
Nicotinamide	150 mg.
Vitamin B ₁₂	6 mcg.
Ascorbic Acid	150 mg.

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officer in the Medical Corps from January 1, 1947 to June 1, 1950 may only be applied as practice on the certification of former chiefs of service.

c) Active duty as a commissioned officer in the Medical Corps for period June 1, 1950 to July 1, 1954 may be applied as one year of residency credit or one year of practice credit regardless of assignment. Service beyond one year may only be applied as practice credit on the certification of former chiefs of service.

d) Active duty as a commissioned officer in the Medical Corps after July 1, 1954 may only be applied as practice credit on the certification of chiefs of service.

e) Residency credit automatically granted for active service in the Medical Corps of the armed forces was discontinued as of July 1, 1954.

Application

Candidates for examination must make an application on prescribed forms which may be obtained from the office of the executive secretary-treasurer. This application must contain a record of the candidate's pre-medical and medical training as well as of his internships, residencies, graduate studies, hospital staff appointments, teaching positions, status in the armed forces and membership in the medical society, medical papers published, and the names of four well known internists to whom the Board may write for

professional and character reference.

The application must be accompanied by one recent, signed photograph and a registration and examination fee of \$40 to cover the cost of the written examination, of which \$25 will be refunded if the application is disapproved. Upon application for admission to the oral examination an additional fee of \$50 will be required. Upon notification of certification by the Board a further fee of \$10 to cover cost of certification will be required.

Application must be filed by May 1st of the year concerned and all requirements must be satisfied by October 1st of the year concerned. The requirements of graduate training followed by two years of practical training in internal medicine must be satisfied, before a candidate is eligible for the examination.

If three or more years elapse before the candidate completes his certification, the Board requires that the candidates file a new application.

Method of examination

The examination is in two parts: Part one is written and part two is clinical (and oral) examination. The written examination is held simultaneously in different sections of the United States and Canada and outside the continental limits of the United States wherever eligible candidates are located.

Only one written examination is

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Physician



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given each year; it is held on the third Monday in October. The examination is divided into a morning and afternoon period of three hours each.

Questions are multiple choice, phrased in such a manner as the Board elects and designed to test the candidate's basic clinical acumen and his knowledge of the basic medical sciences.

Candidates must pass the written examination before admission to the oral examination will be permitted.

Oral examinations are held near the time and place of the annual meetings of the American Medical Association and the College of Physicians and at such other times and places as the Board may designate.

The oral examination is conducted under direct supervision of the Board with the assistance of such examiners as may be selected. Oral examinations are conducted at the bedside of each of two patients previously assigned to each candidate. Forty-five minutes is allowed for the examination of each patient before the candidate is examined orally.

Candidates are expected to present in a concise fashion, pertinent facts on the history and diagnosis. Demonstration of important physical findings will be requested by the examiner. During this examination questions will be asked concerning diagnostic and therapeutic procedures related to the problems under discussion or any other aspects of internal medicine.

The candidate should be prepared to demonstrate his ability to interpret objective demonstrations of x-ray, pathologic, hematologic, electrocardiographic and other abnormalities.

Re-examination

Written. The interval between the first and the second written examination will be not less than one year.

The interval between the second and the third written examination will be not less than two years.

The interval between all written examinations that may be permitted after failure of a third written examination will be two years.

A fee of \$25 is required for each written re-examination.

Oral. The interval between the first and second oral examination will not be less than one year.

The interval between the second and third oral examination will not be less than two years.

A candidate who fails the oral examination for the third time will be required to pass the written examination again before further oral examinations are permitted.

A fee of \$50 is required for each oral re-examination.

Certificates

The certificate issued by the American Board of Internal Medicine is signed by the officers and members of the Board and bears the official seal of the Board.

Report

from Carnation Research Laboratory



Carnation Research Laboratory, 8015 Van Nuys Boulevard, Van Nuys, California

General Research

For a half century, Carnation has conducted a continuous and expanding 5-phase research program in dairy and cereal products. Newest major research facility is the Carnation General Research Laboratory at Van Nuys, California—one of America's most modern laboratories devoted exclusively to product research.

Qualified Scientific Staff

At the Van Nuys Laboratory alone, a large Carnation staff of graduate scientists represents an extremely broad background; fields covered include biology, bacteriology, parasitology, chemistry, biochemistry,

organic chemistry, food technology, dairy husbandry, dairy technology, dairy bacteriology, dairy manufacturing and agricultural engineering.

Continuous, Planned Research protects the uniform high quality of both established and new Carnation products.

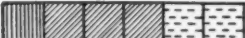

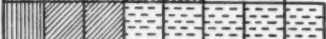

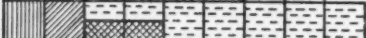


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


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"from Contented Cows"

Alternative Plans to Satisfy Graduate Training Requirements in Internal Medicine

Plans		Required in addition to one year of approved internship.
A		5 years
B		6 years
C		7 years
D		7 years
E		8 years
F		9 years
G		12 years

	Internship
	Full time formal training
	Half-time formal training, as specified (residency or the equivalent)
	Practice of internal medicine

Half-time formal training* under expanded plans B, D and E is defined as follows:

1. Half-time as an instructor in clinical medicine in a recognized medical school in the United States or Canada.
2. Half-time in a research fellowship sponsored by a recognized medical school in the United States or Canada.
3. Half-time as a graduate student in an approved graduate medical school in the United States or Canada.

* Certification by the head of the department in which the work was done is required.

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Delfen vaginal cream

is first in three leading tests
of spermicidal potency.*

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Certificates of the Board are issued to candidates who have satisfactorily completed the written and oral examinations and have been officially certified by the Board.

Subspecialty boards

The subspecialty boards in internal medicine consists of allergy, cardiovascular disease, gastroenterology, and pulmonary diseases. Each subspecialty application is individually considered and acted upon by the subspecialty board concerned. The candidate is not eligible for examination until his application has been approved by the subspecialty board and confirmed by this Board. All candidates must pass the written and oral examination in internal medicine before

admission to examination in a subspecialty. The subspecialty examinations are oral and may be taken at a scheduled subspecialty examination subsequent to the candidate's application in internal medicine.

All official correspondence, applications and detailed information concerning the Board of Internal Medicine should be addressed to: *William A. Werrell, M.D.*, Executive Secretary-Treasurer, One West Main Street, Madison 3, Wisconsin.

Internal Medicine Board Exams

May 1, 1956 is the closing date for applications for written examination of the American Board of Internal Medicine. The written examinations will be held October 15, 1956.

All Or Nothing

I had finished my residency and was home discussing with my family what I would need to open up a pediatric office. My father sat listening. He was from the old country and seldom had much to say. Yet, I had always felt he wasn't quite sure just what a pediatrician could do by way of being a doctor. Finally he said, "Are you going to take care of everybody?"

"No, papa," I said, "I'm going to take care of children up to about 12 years old."

He thought about this for almost a full minute. Then, in mild reproval he said:

"Maybe if you had went to school longer, you take care of older people too?"

P. K., Brooklyn, N. Y.

Equipping the Surgeon's Office

Replies from the survey of general surgeons which formed the basis for this equipping article clearly indicated two types of general surgical practice.

One represents the practice of those surgeons who are some distance from the nearest hospital. Surgeons in this group rely on their own office facilities for a considerable part of their operative work. Equipment is elaborate. Patient care facilities are extensive. Nurses or other trained personnel are employed. In a sense then, surgeons in this group head up an integrated operation, one which might be likened to a hospital in miniature.

The second group of general surgeons, a majority of surgeons responding to the survey, have office facilities which lie at the opposite end of the scale. Very little surgery is done in their offices. In the extreme case, no surgery at all is done "on premises" — but is taken to the hospital. Practically all surgeons, however, make provision for dressings, biopsies, suture removal and certain minor surgical procedures.

What equipment is needed in the beginning practice of general surgery? *Resident Physician* recently put this question to a number of practicing surgeons. Based on their answers, this article is presented as a guide to those residents who will soon be setting up a practice in the specialty. Since cost is an important factor in the selection of equipment, an approximate range of prices has been indicated for each item wherever possible as an aid to the resident in estimating his overall equipment investment.

And though the resident may hope some day to fit into the former group, having every conceivable kind of surgical equipment on hand, generally he will begin his practice in more modest surroundings. This article, then, concerns itself with the beginning practice. Most items discussed are of a "must" variety — although mention will be made of some added starters.

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gentle • prompt • thorough

A modern laxative of choice...

as evidenced by
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Phospho-Soda (Fleet) is a solution containing in each 100 cc.,
sodium biphosphate 48 gm., and sodium phosphate 18 gm.

Office decor

The design and decor of the general surgeon's office, according to our survey, fits itself into one of two distinct categories. First is the "aseptic" type, notable for its "hospital look." Equipment and furnishings are functional in appearance as well as design. Furnishings are liberally-sprinkled with stainless steel and chrome over white enamel. Few embellishments or decorations, simply for the sake of decoration, are visible. The atmosphere is one of business-like efficiency.

The second class of furnishings and appearance, becoming more popular in recent years, is what might be described as the casual, warm type and presenting a home-like and relaxed atmosphere. Color and texture in drapes and carpeting is inviting and appealing to the eye. Natural woods, colored plastics and upholstery are evident in both furniture and accessories. Even the examining room may carry through with this "living room atmosphere" and the equipment is often mahogany, tan or pastel in color, but not white.

Selection of either a "home" or "hospital" decor, as well as the specific furnishings, is best left to the surgeon's own preference. Both are attractive. Each offers advantages and disadvantages, many of which are more aesthetic than practical. Generally speaking, the "hospital" decor is less expensive to attain and maintain.

Waiting room

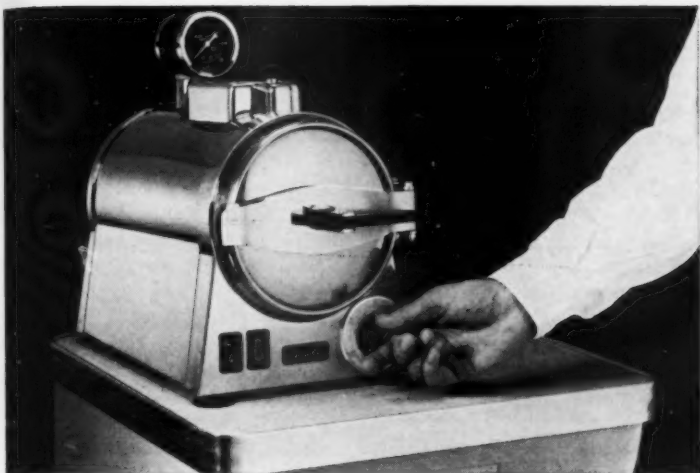
Although similar to that of many specialists, the surgeon's waiting room requires added consideration on two points concerning his patients. The waiting room should be comfortable and completely restful in its atmosphere. Very often the surgical patient, both pre-op and post-op, is apprehensive and tense. Much can be done in the choice of color and texture to make the waiting room soothing and relaxing. Gaudy and garish design, even in minor decorations, is to be avoided. Lighting should be bright but shaded adequately to prevent glare and promote comfort. (Many surgeons stressed this point.)

The size of the waiting room should allow for the fact that many surgical patients are accompanied or assisted to the surgeon's office. The average waiting room of those surgeons responding to the survey made provision for seating six to ten individuals.

Chairs, floor covering

As revealed in our survey, the most common type of waiting room chair in most surgeon's offices is plastic covered wood or metal. This was chosen because it was "economical, attractive and easy to maintain." The number of chairs, of course, depends upon the size of the waiting room; the price of the chair ranged from \$25 to \$40, according to general surgeons queried.

The floor of the waiting room was



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All you do is put materials into the SpeedClave
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No valves to turn—no watching. In 15 minutes
instruments are sterilized *with Hospital Safety*.
(5 minutes less if SpeedClave is hot.) What could
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Then SpeedClave shuts off automatically. Saves
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SAFE NEEDLE?"**

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88 Single Cabinet is ideal
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"Spacemaker" top nearly
doubles your work area.

Dr. _____

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March 1956, Vol. 2, No. 3

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carpeted in 40% of the cases of surgeons interviewed. Price of the carpet including underpad varied from \$7 to \$12 per square yard installed. About 30% had the floor of the waiting room covered with rubber tile; 20% had some form of plastic tile. The average cost of floor covering was \$380 for the entire office. A few comments were: "rubber tile and cork is quieter and softer," plastic tile "is cheaper and easier to take care of," and "carpeting is dignified and adds to a home-like feeling."

The lamps chosen for illumination in the majority of cases were table lamps and the average reported cost was \$35 per lamp. (Prices paid ranged from \$20 to \$55.)

Tables are required for lamps and

magazines. These can be obtained for no more than \$30 to \$40 each. Ashtrays should be present in the waiting room "in quantity" and be of sufficient size. "Used by heavy smokers for more than thirty minutes, the average ashtray will overflow — your furniture and rugs will soon look pretty awful."

Consultation room

The surgeon's consultation room should be roomy and comfortable. The surgeon often finds it necessary to take a rather lengthy history and comfort is important. The desk presents no special problem. It should, of course, be kept in harmony with the decor of the room. Many surgeons are of the massive, multi-drawer desk school; others prefer



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IN EXURBIA TODAY—FAMILIES ARE PLANNED BIG

Exurbia is that area which spreads out luxuriously beyond the suburbs. Here live the authors of the nation's books, plays, advertisements, TV shows—and dreams. A new phenomenon has become part of the Exurbian landscape: the *planned big family*.

Assurance wanted—When Exurbanite wives come for contraceptive advice to help them space their large families, they want to be sure that the method you recommend *really* does a job of protecting them.

Ideal method—Studies show diaphragm-jelly technique gives the greatest degree of protection.¹ It is preferred for women of high parity who want large families—but only *when* they want them. Urban population groups using diaphragm and jelly as recommended have an unplanned pregnancy only “once in ten to 15 years.”¹

Comfort important—With peace of mind goes comfort when the physician prescribes the RAMSES® Diaphragm. Its

cushioned rim guards against irritation; flexibility in all planes permits easy movement. RAMSES Jelly,* a “ten-hour jelly,” used with the RAMSES Diaphragm, immobilizes sperm, is well tolerated, and stays effective for a full ten hours.

Neat TUK-A-WAY® Kit—Patients are confident of receiving sound contraceptive advice when they learn that for *thirty years* physicians have relied on RAMSES Diaphragm and Jelly to help *plan* big families. RAMSES TUK-A-WAY Kit, #701 (diaphragm, introducer and jelly), RAMSES Diaphragms 50-95 millimeters in size, RAMSES Jelly in 3 and 5 oz. tubes.

1. Tietze, C., in Dickinson, R. L.: *Techniques of Conception Control*, ed. 3, Baltimore, Williams & Wilkins Co., 1950, pp. 55-57.

RAMSES and “TUK-A-WAY” are registered trade-marks of Julius Schmid, Inc.

*Active agent, dodecaethyleneglycol monolaurate 5%, in a base of long-lasting barrier effectiveness.

JULIUS SCHMID, INC.

423 West 55th Street, New York 19, N. Y.

to keep papers and forms in a cabinet and use a small one-drawer desk for history taking, etc.

A good desk can be purchased for as little as \$75. "But it's easy to find one for \$500 if you have nothing better to do with your money," said one surgeon. Average price paid by our responding surgeons was under \$200. The desk may or may not require a lamp of some sort. If one is chosen it should be chosen with the thought in mind that it should illuminate only the desk surface—not get in the patient's eyes. A good desk lamp may be had for under \$50.

The surgeon (as most specialists) can profitably devote special consideration to his own desk chair. "Get one to fit—you'll spend plenty of hours in it. . . ." advises one surgeon. The average prices quoted for such a chair was \$75 to \$150.

Two additional chairs should be in the room, one for the patient and one for a relative or friend. These chairs can be less expensive and should cost no more than \$75 each. Some surgeons reported having a couch in their consultation room (usually covered with leather or plastic). Such a couch, if wanted, can be purchased for a price of between \$150 and \$250.

The decoration of the consultation room should be restrained and dignified. Diplomas and credentials should be attractively framed. "They are decorative and impressive" and "give the patient tangible evidence

that his confidence in the surgeon is well-placed."

Bookcases are needed. These can be attractive and should be in harmony with other furniture in the room. They need not be expensive to be well built.

Examining room

The examining room in a surgeon's office usually contains an examining table, a treatment stand, a treatment cabinet, and a good lighting arrangement. The surgeon may have another room for his minor surgery.

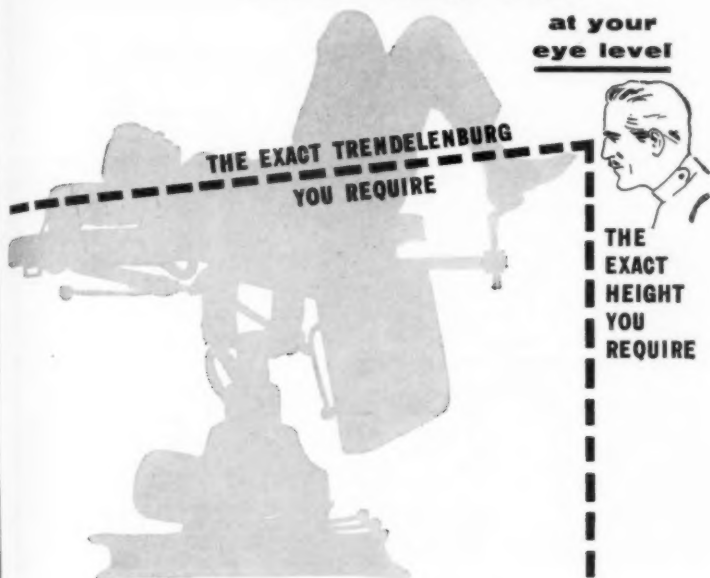
In general, the *examining table* should be sturdy and should either be adjustable in height or have a step stool for the patient. An electrical outlet is a convenient accessory. An examining table can be bought new at prices from \$200 to \$800. Secondhand tables may be obtained in some localities for a price as low as \$50 plus extra for re-painting and conditioning (\$10-\$25).

Operating tables were reported by 20% of the surgeons interviewed. Many of these surgeons were in areas far from hospitals. Tables were primarily of the "hospital" type, are adjustable to a number of different positions which the surgeon requires in his operating procedures. The cost of these tables varied from \$800 to \$1200 and more, according to respondents.

Treatment stands and cabinets, necessary to hold instruments and other apparatus, can be purchased for \$75 to \$200.

ONLY THE RITTER UNIVERSAL TABLE GIVES YOU . . .

at your
eye level



. . . SO EASILY

For GYN examinations or treatment, *only* the Ritter Universal Table gives you the *exact* Trendelenburg and *ideal* table height you require . . . without physical effort.

Seated on your Ritter stool you elevate the patient to your most convenient examining level with a light touch of your toe . . . easily, smoothly, quickly . . . quietly. Easy turn of the hand wheel tilts the patient to the desired degree of Trendelenburg.

This is just *one* example of the famous 12 basic positions of the Ritter Universal Table. Call your Ritter dealer for more information and a demonstration . . . or write the Ritter Company, Inc., 5315 Ritter Park, Rochester 3, New York.

Ritter



Company Inc.

Some method of instrument sterilization is needed. Nearly 40% of our survey respondents reported they had an autoclave in their offices; the average price given was \$250 to \$300. The remainder of surgeons responding used conventional water sterilizers. Prices here were generally under \$75.

Special equipment

Three out of ten surgeons stated they used a diathermy machine in their offices. Surgeons in this group reported a large compensation practice. The price of diathermy equipment is \$700 to \$800. Roughly 20% of the responding surgeons had an ultrasonic apparatus; reported costs ran around \$500.

BMR equipment was present in 25% of the offices surveyed. Those who had such an apparatus admitted it was used in their practice because they were interested in thyroid procedures; but they indicated that the added expense of such equipment would probably eliminate it from consideration in the beginning practice. This apparatus costs from \$400 to \$700.

A microscope is part of the surgeon's equipment and will cost \$250 or more new or \$175 secondhand.

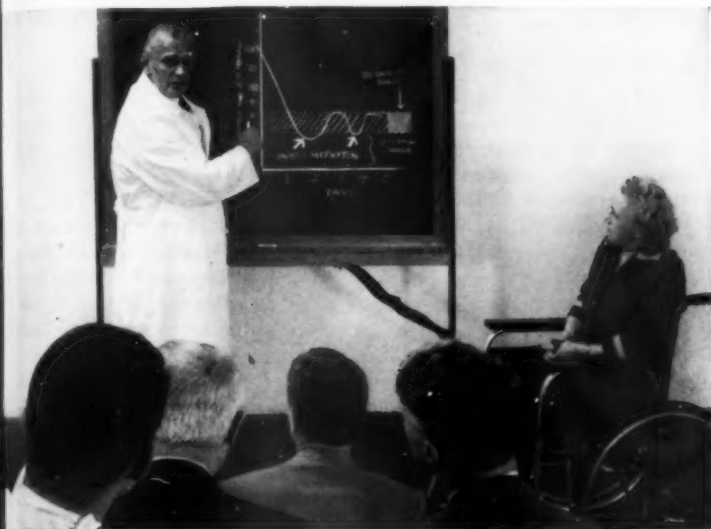
Minor surgical instruments and drugs needed to stock the new office usually average no more than \$150 combined, according to our survey.

Illumination in this room is extremely important; the type of light



"Er . . . ah . . . number 34 in for 75!"

adjusts anticoagulant-depressed prothrombin time



MAJOR ADVANTAGES: Action detectable within 15 minutes, prothrombin time normalized within 4 to 12 hours, bleeding checked in 3 to 6 hours.

EMULSION OF **Mephyton**[®] (VITAMIN K₁ INJECTION, MERCK)

It is shown that oil-soluble vitamin K₁ is more effective than any other agent now available in combating drug-induced hypoprothrombinemia.¹ However, the usefulness of Mephyton lies not only in overcoming bleeding emergencies, but also in adjusting upwards to safe therapeutic levels unduly prolonged prothrombin times without gross changes in the regular anticoagulant dosage.

INDICATIONS: Hypoprothrombinemia due to Dicumarol[®], Coumatelan[®], Tromexan[®], Hedulin[®], 'Dipaxin', warfarin and other phenylindanediones.

SUPPLIED: In boxes of six 1-cc. ampuls, each cc. containing 10 mg. of vitamin K₁.

Gamble, J. R., et al., *Arch. Int. Med.* 95:52, January 1955.

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selected should be one that offers a bright, shadowless light and can be focused. The price of a suitable light varies from a low \$25 to a high of about \$250.

X-ray

An x-ray machine was found necessary by 20% of the surgeons interviewed. Most felt the expense of such a machine was offset by the income derived from it. The majority of surgeons did not think an x-ray machine was "necessary for the beginning surgeon." One reported: The few cases where an x-ray may be indicated in the early years of practice can easily be referred."

The type of machine purchased varied and price depended primarily on the size and capacity. A 100 MA machine is priced at from \$3,000 on up.

Other instruments needed will depend upon the individual surgeon. A sigmoidoscope may be added to the list if this procedure is to be done in the surgeon's office, a bronchoscope, too, may be added.

Other rooms

In many surgeon's offices there is an extra room, a "utility room." It may consist of a small laboratory, a place to clean and sterilize instruments and gloves, perhaps a small table where the patient can receive diatherm therapy. Laboratory equipment needed for the general surgeon in the beginning, that is equipment sufficient to do blood counts, sedi-

mentation rates and urines, should cost no more than \$35 to \$50. A simple upright, rigid table where patients can receive ultrasonic or diatherm therapy can cost as little as \$35 to \$50.

Anesthesia

A big item and one which may be needed in some localities is anesthesia equipment. Most surgeons in large cities reported they did not prefer to give general anesthesia in the office, feeling that such cases "should be operated on in the hospital." In smaller localities some surgeons find it necessary to have this equipment in their office.

Many surgeons used electric cautery in their first year, some 60% of the interviewed surgeons. Such an apparatus, of sufficient size and intensity to accomplish the work required may cost as much as \$350.

Dressing room and lavatory

Since these rooms are used so frequently, special care should be taken in furnishing them. The dressing room should be separated from the lavatory and adjacent to the examining room. It should be well-lighted, have a seat and a mirror. Hangers and hooks should be supplied for clothing and gowns. The door should be able to be locked from within. The total cost of dressing room equipment is usually less than \$75.

The lavatory, aside from being readily available to both the waiting



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GENERAL  ELECTRIC

room and the examining room, should contain a wash bowl, stool, a mirror, shelf, waste basket, soap and towels. Your nurse will have access to sanitary items and will make this known to each patient.

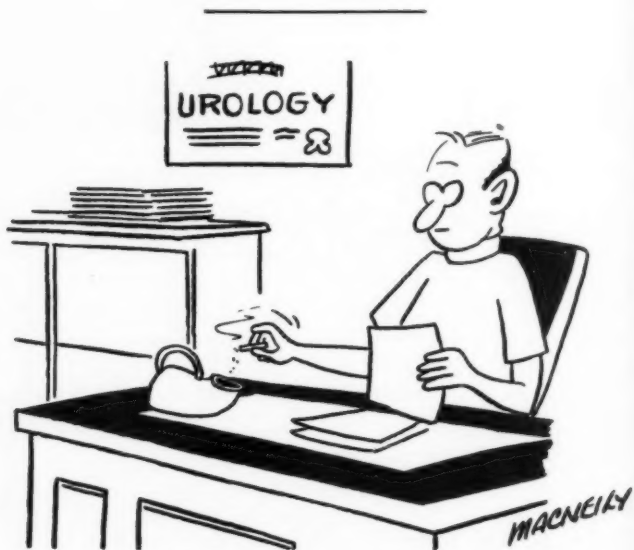
In summary, the total cost of office equipment of those responding to the RESIDENT PHYSICIAN survey was as little as \$2,300 to a bit over \$5,000.

There are two ways in which a resident can get a head start: 1) consult an office equipment company

which maintains an advisory staff having experience in equipping doctor's offices, and 2) make a tentative list of equipment items you think you'll need immediately—together with cost estimates.

Reprints of this and previous articles in the series (Internist's Office, Pediatrician's Office, Ob-Gyn Office and Ophthalmology Office) now available from the publisher at 30 cents (in coin or stamps) for each copy.

Next month: Equipping the Urologist's Office





What's the Doctor's Name?

James Gallagher

He was born November 21, 1729, at Amesbury, Mass., and died May 19, 1795.

At the age of 16 he began the study of medicine in the office of a kinsman, Dr. Ordway, and started practice in 1750, in the town of Kingston, N. H.

Married Mary Barton on January 15, 1754. They had twelve children; three of their sons and seven of their grandsons became physicians.

At the Continental Congress, as a delegate from New Hampshire, 1775-76, he was the first to give his vote in favor of the adoption of the Declaration of Independence, to which his name was duly affixed. He also had the honor of being first to vote for the proposed Articles of Confederation and Perpetual Union which took effect March 1, 1781.

In 1779, New Hampshire appointed him chief justice of its Court of Common Pleas. In 1782, he was

promoted to associate justice of the Superior Court, became chief justice in 1788, and ended his service on the bench in 1790.

In 1790, and in each of the two following years, he was elected to the highest office in the state, that of chief executive (then called "president").

In June 1793, the newly amended state constitution having changed the title, he was chosen as the first governor of the state.

In 1790, Dartmouth College conferred upon him the honorary degree of Doctor of Medicine.

He was elected first president of the New Hampshire Medical Society.

His portrait in oil was painted by Jonathan Trumbull, and a bronze statue of him, unveiled in 1888, stands in the public square of his native town.

Can you name this doctor without turning to page 146.

Mediquiz



1. A 35-year-old man has symptoms of intermittent palpitations, anxiety, excess perspiration. Examination reveals a blood pressure reading of 190/110 mm. Hg and glycosuria. Basal metabolic rate is + 50 percent, cholesterol 265 mg./100 cc., fasting blood sugar 167 mg./100 cc., and an intravenous histamine test produced a rise in blood pressure reading to 260/160 mm. Hg; whereas, a cold pressor test was negative. Of the following, the best diagnosis is: (A) arterio-sclerotic heart disease and diabetes mellitus; (B) pheochromocytoma; (C) hypertensive vascular disease and anxiety state; (D) adrenal cortical carcinoma.

2. A 50-year-old male has had two hours of crushing substernal pain radiating down both arms and through to back; his skin is pale, cold and moist, his blood pressure reading is 90/60 mm. Hg. Electrocardiogram shows Q waves in chest leads "consistent with old infarc-

Questions are from a civil service examination recently given to candidates for physician appointments in municipal government.

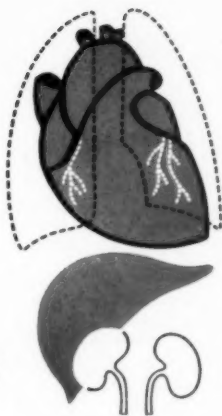
Answers will be found on page 142.

tion." Shortly after admission, pain extended to the left leg, and pulses disappeared in the femoral arteries. Urinalysis shows 10 red blood cells per high power field. Of the following, the best diagnosis is: (A) dissecting aneurysm; (B) ureteral colic due to stone; (C) myocardial infarction; (D) arterial embolism.

3. A 50-year-old man complains of spongy gums that bleed easily. Complete blood count, blood smear, Rumpel-Leeds test, bleeding time, clotting time and clot retraction time are all within normal limits. Of the following, the next indicated step in evaluating the complaints is: (A) bone marrow biopsy; (B) determination of percent of prothrombin consumption in clotting; (C) referral of patient to a dentist for evaluation; (D) therapeutic trial of "rutin" to try to restore capillary integrity.

4. A man of 25 years has cholelithiasis and cholecystitis; he reports that gallstones have occurred among many of his relatives below the age of 30. The one of the fol-

know your diuretic



how safe is the diuretic you prescribe?

the utmost in safety, confirmed by long clinical usage, is one reason more physicians choose the organomercurials for diuresis. Their dependable action does not involve production of acidosis or specific depletion of potassium, and side effects due to widespread enzyme inhibition are absent.

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no "rest" periods • no refractoriness

NEOHYDRIN can be prescribed every day,
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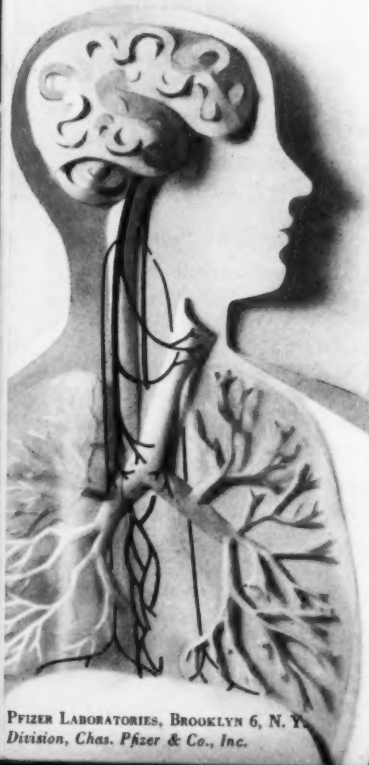
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Selective cough control through...



lowing diseases which would not be suggested by this history is: (A) hypercholesterolemia; (B) Thalassemia (Cooley's anemia); (C) pseudohemophilia; (D) familial hemolytic icterus.

5. In a case of suspected benzol poisoning, the most useful information is likely to be obtained by an examination of the: (A) liver; (B) blood; (C) kidneys; (D) lungs.

6. Of the various types of radiation listed below, the one which has the greatest penetrating power is radiation with: (A) gamma rays; (B) alpha rays; (C) ultraviolet rays; (D) beta rays.

7. Of the following combinations of chemical findings, the one most usually found in tetany due to hypoparathyroidism is: (A) low serum calcium, low serum inorganic phosphate, normal serum alkaline phosphatase, (B) low serum calcium, high serum inorganic phosphate, normal serum alkaline phosphatase; (C) low serum calcium, high serum inorganic phosphate, high serum alkaline phosphatase; (D) low serum calcium, high serum inorganic phosphate, low serum alkaline phosphatase.

8. The radioactive iodine tracer test of thyroid function should not be used in the presence of: (A) leukemia; (B) heart failure; (C) uremia; (D) pregnancy.

9. The one of the following fractures for which open reduction is rarely indicated is: (A) fracture of the neck of the femur; (B) supracondylar fracture of the humerus; (C) fracture of the olecranon; (D) fracture of the patella.

10. The proper treatment of a comminuted fracture of the head of the radius with displacement is: (A) immobilization in plaster; (B) sling with early motion; (C) excision of the fragments of the head of the radius; (D) immediate aspiration of blood from the elbow joint.

11. Kayser-Fleischer rings are usually associated with: (A) erythema circinatum; (B) quartan malaria; (C) hepatolenticular degeneration; (D) Gaucher's disease.

12. A man, aged 50, complains of passing small amounts of fresh blood per anus after each bowel movement. There are no other complaints, but the feces frequently have streaks of fresh blood on the surface. Of the following, the type of additional examination which is most likely to establish the diagnosis is: (A) barium enema with x-ray examination; (B) proctosigmoidoscopic examination; (C) examination of stool for ova and parasites; (D) Papanicolaou stain and study of exfoliated cells from freshly passed feces.

13. Steatorrhea is an uncommon finding in: (A) non-tropical sprue;

...selective
inhibition of
the cough
reflex with

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BRAND OF CARBETAPENTANE CITRATE

non-narcotic, non-opiate, highly palatable antitussive agent

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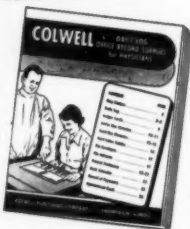
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(B) pellagra; (C) cystic fibrosis of the pancreas; (D) celiac disease.

14. Trichobezoar usually implies: (A) granuloma of rectum; (B) intestinal parasitic infestation; (C) fecolith in appendix; (D) hair ball in stomach.

15. The spinal fluid sugar is most likely to be reduced in: (A) lymphocytic choriomeningitis; (B) St. Louis encephalitis; (C) general paresis; (D) tuberculous meningitis.

16. Of the following diseases, the one in which leukopaenia is most characteristic is: (A) kala-azar; (B) leptospirosis; (C) actinomycosis; (D) lobar pneumonia.

17. Of the following diseases, the one due to infection with Rickettsia is: (A) psittacosis; (B) herpes simplex; (C) Q fever; (D) yaws.

18. Of the total time lost from work by employees in the United States due to illness and injury, the percentage due to occupational causes is most nearly: (A) 10%; (B) 35%; (C) 50%; (D) 70%.

"MEDIQUIZ" ANSWERS

1(B), 2(A), 3(C), 4(C), 5(B), 6(A), 7(B), 8(D), 9(B), 10(C), 11(C), 12(B), 13(B), 14(D), 15(D), 16(A), 17(C), 18(A).

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bed General Medical and Surgical Hospital,
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pital, Hines, Illinois.

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surgeon. Ideal for man finishing residency.
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PATHOLOGY RESIDENCY—available June or July, 1956; approved 4 years in pathologic anatomy and clinical pathology; 400 bed hospital; 170 autopsies, 6000 surgicals; salary \$2000-\$3000 plus full maintenance. Apply: Pathologist, Hillcrest Medical Center, Tulsa, Oklahoma.

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PHYSICIAN—staff associate; private psychiatric hospital in beautiful Finger Lakes region of New York State; full maintenance for couple available; salary commensurate with experience and training. Contact: Brigham Hall Hospital, Canadaville, New York.

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RESIDENCIES AVAILABLE: Modernly equipped 516 bed, GM&S, fully approved V.A. Research Hospital; affiliated with Northwestern University Medical School; openings now for residents in internal medicine, general surgery, pathology, physical medicine and rehabilitation, diagnostic radiology and therapeutic radiology available Jan. 1, 1956 and July 1, 1956. Must be citizens and graduates of approved schools. Stipend 2840-3550. For information write: Director, Professional Services, V.A. Research Hospital, 333 E. Huron St., Chicago 11, Ill.

UROLOGIST: Board or eligible; citizenship required; 382 bed medical and surgical hospital; salary \$8,990 to \$13,760, depending on qualifications. Quarters may be available. Contact: Manager, VA Hospital, Muskogee, Oklahoma.

GENERAL PRACTICE RESIDENCIES—In University of Colorado Medical Center Hospitals; available January 1st, and July 1st. Apply to: Office of Postgraduate Medical Education, 4200 E. 9th Avenue, Denver, 20, Colorado.

CHIEF RESIDENT: medical or surgical residents needed on 7/1/56; Cincinnati, Ohio hospital; for 150 bed hospital. Teaching program one year approved AMA residencies. The Deaconess Hospital, Cincinnati 20, Ohio.

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RESIDENTS WANTED

PSYCHIATRIST WANTED — state hospital, South Blackfoot, Idaho; has opportunity for Board eligible or experienced psychiatrists as director of research and education and as staff psychiatrist, must be eligible for Idaho license; salary competitive; practice involves devoting at least half-time to interview therapy; opportunity for limited private practice; hospital has 800 patients; 8 psychiatrists; 5 clinical psychologists; unique organization for professional work; won 1954 Mental Hospital Achievement Award; only well qualified psychiatrists need apply. Contact: J. O. Cromwell, M.D., Superintendent, Box 390, Blackfoot, Idaho.

FELLOWSHIP IN RADIOLOGY—St. Luke's Hospital, Chicago, Illinois will appoint 3 Fellows April 1, 1956. Fellowship 3 years. Approved by A.M.A. and American Board of Radiology; special work in cardiovascular roentgenology, cerebral angiography, radium and cobalt therapy; affiliated with Northwestern University Medical School and Veteran's Research Hospital; five months (46 hrs.) didactic course in radiobiology and physics each year; stipend \$100.00 per month, room, board and laundry. Direct reply to E. L. Jenkinson, M.D., Director, Dept. of Radiology.

INTERNAL MEDICINE RESIDENCY—1100 bed hospital; 3 year approved, active teaching unit of Baylor University College of Medicine; female services, research, cardiology, gastroenterology, renal vascular diseases, hematology, endocrinology, pulmonary function, etc. Board certified specialists in all fields. \$2840 to \$3550. Must be U. S. citizen. H. D. Bennett, M.D., VA Hospital, Houston, Texas.

PATHOLOGY RESIDENCIES, University of Kansas Medical School and V.A. Hospital; 4 year program for certification, 1 year program for residents other specialties; 12 full time staff pathologists, 10,000 surgicals, 700 autopsies, clinical pathology, research; \$1500 to \$6000; U.S. citizens preferred. Apply Dr. R. E. Stowell Kansas City 12, Kansas.

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WHAT'S THE DOCTOR'S NAME?

(from page 137)

Josiah Bartlett

VIEWBOX DIAGNOSIS

(from page 15)

CARCINOMA OF THE STOMACH

Note the irregular extensive filling defect in the distal two-thirds of the stomach, with effacement of the rugae, rigidity, absence of peristalsis and partial obstruction.

RESIDENT RELAXER

(puzzle on page 17)

A	M	A		E	N	E	M	A		B	I	B		
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